

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES**

**STIGMA AND DISCRIMINATION AGAINST AIDS
ORPHANS IN ADDIS ABABA, NAZARETH AND AWASSA**

**A THESIS SUBMITTED TO THE SCHOOL OF
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ADDIS ABABA UNIVERSITY**

**BY
TEDLA DIRESSIE**

July, 2005

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**IN PARTIAL FULFILMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTERS OF ARTS IN SPECIAL
NEEDS EDUCATION**

**BY
TEDLA DIRESSIE**

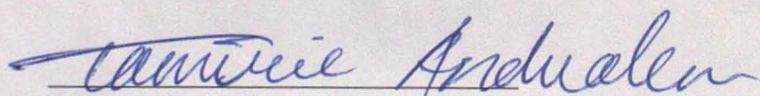
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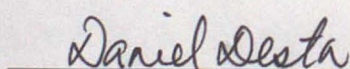
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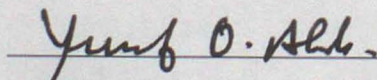
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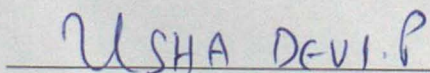
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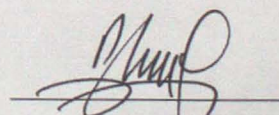
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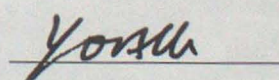
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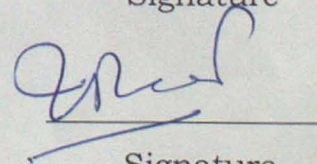
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ACRONYMS

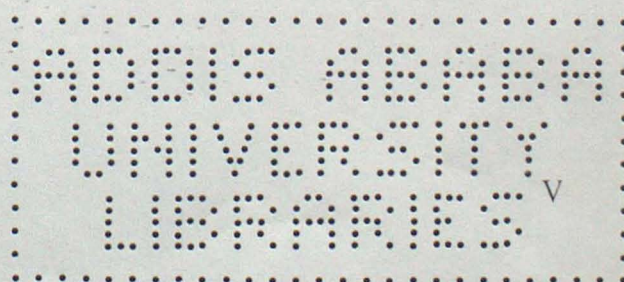
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retroviral Drug
BSS	Behavioral Surveillance Survey
CRC	Convention on the Rights of Child
CSA	Central Statistics Authority
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
FORUM	Forum on Street Children- Ethiopia
FGD	Forum on Street Children-Ethiopia
HAPCO	HIV/AIDS Prevention
HIV	Human Immunodeficiency Virus
IC	Italian Cooperation
ICRW	International Center for Research on Women
IFSO	Integrated Family Service Organization
ISAPSO	Integrated Service for AIDS Prevention and Support Organization
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
NGO	Non-Governmental Organizations
OSSA	Organization for Social Services for AIDS
OVC	Orphans and Vulnerable Children
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mothers to Child Transmission
SNNPR	Southern Nations, Nationalities and Peoples Region
SPSS	Statistical Package for Social Scientists
UN	United Nations Organization
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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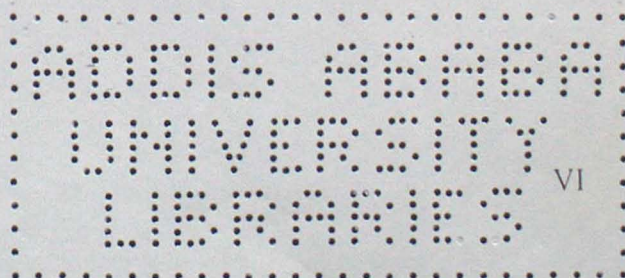
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ABSTRACT

HIV and AIDS is a pandemic that is deadly and hard to control. It extremely concerns human being in that it affects economic, social and cultural development of the society. In Ethiopia, the epidemic has been tragically snatching the lives of our people since its appearance about twenty years ago. Quite a lot of children have been left with out a mother or a father or both. The number of orphans accounts for about 1.2 million in 2001. It is highly associated with stigma and discrimination. The society understood stigma and discrimination poorly. The existing programs attempt to address mainly the problems of adults. Researches that reveal stigma and discrimination in connection with AIDS orphans are unavailable. Such situation necessitated the undertaking of this research.

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

HIV and AIDS pandemic has become a critical concern of our planet earth. Today, between 35 million and 42 million people are living with HIV and AIDS across the world. Around 25 million of them live in the African continent, where so far, more than 13 million people have already died from AIDS (2.2 million in 2003 alone). HIV prevalence rates across the African continent vary widely. Southern Africa is most severely affected, with more than 16% of its adult population being HIV-positive. Average levels of prevalence are lower in East Africa (6%) and West and Central Africa (4.5%), and much lower in North Africa (under 0.5%). Depending on the context, these variations produce different economic impacts in the societies of the region. Regardless of these variations, the number of people living with HIV across Africa continues to grow. Faced with a disease that is both deadly and hard to control, many have preferred to deny its existence and to stigmatize those who have the infection. These attitudes, combined with lack of access to treatment services, help to explain why an estimated 95% of men and women across Africa do not know their HIV status (UNAIDS, 2005).

The first case of AIDS was clinically diagnosed in the United States of America in 1981 (WHO, 1991). It was in the 1980s that the first AIDS case was found in the Sub-Saharan region, Central and Eastern Africa (Karen, 2002). Similarly, in Ethiopia, the first evidence of HIV infection was discovered in serological samples collected in 1984 (Tsega et al. 1988) and was followed by the first reported cases of AIDS diagnosed in a laboratory in 1986 (Lester et al., 1988); both cited in (BSS, 2002). This same document reveals that data regarding the number of reported AIDS cases, areas of residence, and high-risk groups are available

only for the years up to and including 1994. More recent data are not available because of under diagnosis or under reporting or delayed reporting practices.

According to the report of the Ministry of Health (2002), the prevalence of adults with HIV infection was 6.6%, which had been 7.3% in 2001, of the total population of Ethiopia. The number of orphans had been 1.2 million in 2001 and the number was projected to increase to 1.8 million in 2007 and, if no change will be made in the situation, it may be aggravated to soar up to 2.5 million in 2014.

HIV and AIDS is not only a fatal epidemic that has no cure, but it is also associated with stigma and discrimination for no apparent and logical reasons. Since the beginning of the HIV and AIDS epidemic, people living with HIV and AIDS have been the targets of stigma and discrimination. Stigma and discrimination jeopardize the normal function and participation of the affected and infected individuals in the social activities. Stigma, which results in and expressed through discrimination in the social settings is also a serious and unabated problem associated with HIV and AIDS.

HIV and AIDS-related stigma remains poorly understood particularly in low or middle-income countries. Experience of people living with HIV and AIDS, the forms of stigma manifested, in the community, in the school, in the play ground, and the impact of stigma on participation of people living with HIV and AIDS in activities of their communities have not been realized properly. This could be due to the reason that the problem of HIV and AIDS has been a recent phenomenon. The reaction of the society initially focused on the management of the crisis associated with the health, economic, care and support of the victims. The major concern seemed to have been the knowledge of the transmission of the virus. The realization of the psychological impacts that had been attached to stigma and discrimination seemed to have come at the later stage. Even then, stigma and

discrimination was seen mainly from the perspectives of the adult PLWHA in isolation from the AIDS orphans. Recognizing that AIDS orphans have complex and compounded economic, social and psychological problems and need special care, support and protection, the issue of stigma and discrimination they face have not been addressed directly. Thus, this research attempts to examine stigma and discrimination associated with AIDS orphans.

The researcher, in this document, preferred to use HIV and AIDS as it had been used in ICRW (2003) instead of using the conventional terms - HIV/AIDS. The reason for doing so is that the two terms differ in that HIV refers to the virus and a person living with the virus may not necessarily manifest symptoms and sickness that result from it while a person with AIDS manifests the symptoms and sickness caused by the virus. Though the HIV is the cause for becoming AIDS patient. Both terms reveal varying stages of the HIV situation. Thus the usage of the term HIV and AIDS may minimize confusion resulting from the term HIV/AIDS. The other point is that if one manages to harmoniously live with the virus through self-care and protecting oneself from harmful practices that jeopardize her/his health, she/he can live long. So, this may imply that children cannot be orphaned due to the virus but they may be orphaned from AIDS. The researcher also believes that appropriate terms help readers to clearly understand the concept of an issue and effectively address a particular problem.

1.2 Statement of the Problem

Due to the long-standing concerns about AIDS-related stigma and discrimination, prevention efforts have largely avoided interventions directed at individuals who are HIV infected, the very persons who are in a unique position to stop the spread of HIV. HIV and AIDS-related stigma is manifested through discrimination and social ostracism directed against

individuals with HIV and AIDS, against groups of people perceived to be likely infected, and against those individuals mainly AIDS orphans, and groups with whom PLWHA interact or they are associated. These are, therefore, the critical issues to be examined in this research.

It is known that HIV-related stigma and discrimination are poorly understood in Ethiopia. Scholars in the area believe that HIV-related stigma is complex, dynamic, and deeply ingrained. The discriminatory problems associated with it on orphans are enormous even more serious than it appears on adults. There are, in fact, various intervention programs aimed at addressing the issues generally related to HIV and AIDS of which stigma may be a component. Among the programs being undertaken, workshops, dramas, dispatching of leaflets, fliers, banners, posters etc, are worth mentioning. These undertakings over the years carry slogans such as "Avoid stigma and discrimination against people living with HIV/AIDS", "love them" etc. However, the activities seem to have been merely designed to address the problems of the adult group and have not been specifically planned for AIDS orphans. In addition, though there are intervention programs to mitigate the problems, comprehensive information regarding their impacts on AIDS orphans is unavailable in the country.

Government and non-governmental organizations working in the area of HIV and AIDS have been trying to address the issue of HIV and AIDS-related stigma and discrimination in the context of adult population. The available researches related to the various problems associated with stigma and discrimination reveals matters pertaining to adult population. The researcher could not find any research document concerning HIV and AIDS-related stigma and discrimination against AIDS orphans. Not only were the problems that have not been well understood, the programs designed to address the issues are not in consideration of the problems of the orphans either. Hence, it is difficult to say that there have been

intervention programs particularly undertaken to ameliorate the problems of such children. Thus, any program related to the issue of HIV and AIDS-related stigma and discrimination needs to be designed and undertaken on the basis of researches. Since children's perspectives and opinions generally are not considered, projects often fail to address children's real problems.

Therefore, the forms of the discrimination as well as where and when it occurs need to be identified. Whether or not the stigma has been due to the death of their parents as a result of the virus or because of any other factors have to be investigated. Whether or not the intervention programs, which have been underway, are appropriate enough to serve their purposes in relation to stigma and discrimination against AIDS orphans haven't been assessed and made available. The issues concerning AIDS orphans with particular emphasis on stigma and discrimination should be given special attention, for the situation they are in affects their overall development. In this connection, the overall situations of the AIDS orphans in this regard have to be examined.

Documented efforts to challenge HIV and AIDS-related stigma and discrimination against orphans are relatively rare, if not, unavailable. Since the nature of HIV and AIDS has not yet been absolutely understood, it obviously needs further researches. For all practical purposes in this regard, research is urgently needed to see the scenario of HIV and AIDS-related stigma and discrimination and to partial out the most effective ways of tackling the problems that result from stigma and discrimination across a range of contexts.

Thus, such situation necessitated the undertaking of this research with the aim of answering the following questions:

1. What are the factors that triggered HIV and AIDS-related stigma, and discrimination?

2. What makes HIV and AIDS unique from other killer diseases in terms of stigma?
3. Do the intervention programs focus on identified causes of HIV and AIDS-related stigma separately?
4. Are there stand-alone intervention programs to tackle HIV-related stigma and discrimination against AIDS orphans?
5. Are the intended objectives achieved through the interventions undertaken so far?
6. What are the weaknesses observed in the programs undertaken?
7. What other measures should be taken along with the existing programs to make a difference?

1.3 Objectives of the Study

The study will be conducted with the aims of attaining the following objectives:

1.3.1 General Objective:

The study is intended to gather information on the situation of HIV and AIDS-related stigma and discrimination against AIDS orphans and gives recommendations, which may help to develop future courses of action.

1.3.2 Specific Objectives:

The specific objectives of this study are to:

1. Compile reflections of AIDS orphans, practitioners and/or professionals, and people living with HIV, regarding HIV and AIDS- related stigma and discrimination
2. Obtain information whether or not HIV and AIDS-related stigma and discrimination is different from stigma and discrimination caused by other killer diseases
3. Assess the forms of stigma and discrimination associated with AIDS orphans
4. Find out the psychosocial impact of HIV and AIDS-related stigma and discrimination against AIDS orphans
5. Examine the implications of the intervention Programs which have been underway to address the problems of AIDS orphans
6. Forward recommendations that would be of help to prevent, redress, and eventually eliminate HIV and AIDS-related stigma and discrimination against orphans.

1.4 Significance of the Study

Identification of the underlying causes that trigger HIV and AIDS - related stigma and the associated discrimination is fundamental prior to designing intervention programs aimed at reducing the associated negative effects of them on children. Most of the programs planned to address issues related to HIV and AIDS in Ethiopia give much emphasis to adults. There seems to appear less focus on HIV and AIDS- related stigma and discrimination against orphans and vulnerable children. Attempts to handle

the cases of such children could only be effective when relevant data is available.

Government and non-government organizations that have care and support programs for AIDS orphans will be able to obtain relevant information so as to extend the existing programs or to replicate, make some modifications or to initiate new programs in connection with stigma and discrimination. The knowledge of the prevalence and magnitude of the problems along with their various forms of manifestations is a prelude to the preparation of any intervention program. Therefore, It was with this intention that this research had been designed.

1.5 Scope of the Study

This study does not absolutely attempt to address all matters concerning AIDS orphans in the country. It is rather de-limited to only issues related to HIV and AIDS-related stigma and discrimination against AIDS orphans who are registered in eight non-governmental organizations operating in the cities of Addis Ababa, Nazareth, and Awassa.

Four organizations have been selected from Addis Ababa, two from Nazareth and two from Awassa. If one sees the scope of the study in terms of regions, it seemingly covers three regions, namely, Addis Ababa, Oromia and The Southern Nations, Nationalities and Peoples Regional State. However, it represents the situation of stigma and discrimination against AIDS orphans only in the cities mentioned here in above.

1.6 Limitation of the Study

Because some of the AIDS orphan respondents were in their middle childhood age, there is a fear that they might have not openly expressed their feelings due to shyness or lack of clear understanding of the

questions. Some of them might have concealed information while some others might have been reserved from releasing relevant information.

Another limitation could be the difficulty to distinctively identify the AIDS orphans from the non-orphans. Because most of the orphans do not openly declare that their orphan-hood occurred due to AIDS. One cannot openly ask them whether they are AIDS orphans or not, for doing so entails the violation of human rights. Only a few of the orphans tell that the death of their parents was due to AIDS. Those people who provide care and support for the full-blown AIDS patients have the knowledge about the cause for the death. These people classify children of such patients as AIDS orphans. Thus, there seems to be possibilities for non-AIDS orphans to be registered. NGOs register the children who are labeled as AIDS orphans based on the information obtained from the community.

As this study focuses on AIDS orphans registered by the respective non-governmental organizations, those AIDS orphans outside the focus of these institutions were not captured.

1.7 Definition of Terms

The excerpts of the following definitions are taken from various documents related to the issues under research as well as from what people conventionally use. Thus, the following terms are worth defining to better fit the study:

- **Child:** refers to every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier (CRC, 1989).
- **AIDS orphan:** a child below the age of 18 who has lost one or both parents or lives in a household with an adult death (age 18-59 years) or is living outside a family care (UNAIDS/UNICEF, 2003)

- **Maternal orphan:** A child, below the age of 18, who lost her/his mother to AIDS (ICRW, 2003)
- **Paternal orphan:** A child, below the age of 18, who lost her/his father to AIDS (ibid)
- **Double orphan:** A child, below the age of 18, who lost both parents to AIDS (ibid)
- **HIV and AIDS- Related Stigma:** can be described as a "process of devaluation" of people either living with or associated with HIV and AIDS (ICRW, 2005)
- **Stigma:** An attribute that is deeply discrediting and results in the reduction of a person or group from a whole and usual person to a tainted, discounted one (Goffman, 1963).
- **Discrimination:** is a negative act that results from stigma and that serve to devalue and reduce the life chances of the stigmatized.
- **Attitudes:** Learned predispositions to respond in a favorable or unfavorable form of manner to a particular person, behavior, or object (Robert S.Feldman, 1996)
- **HIV:** Human Immunodeficiency Virus, responsible for AIDS
- **AIDS:** Acquired Immune Deficiency Syndromes, Produced by HIV
- **UNAIDS:** United Nations Joint Program on HIV and AIDS or a global coalition of United Nations agencies (World Health Organization, WHO; United Nations Children's Fund, UNICEF; United Nations Development Program, UNDP; United Nations Fund for Population Activities, UNFPA; United Nations Educational, Scientific, and Cultural Organization, UNESCO; The United Nations Drug Control Program, UNDCP; and the World Bank)
- **Epidemic:** A disease that affects a large number of people in a particular location within a relatively restricted time frame. It refers, usually, to infectious disease in a country or certain locality
- **Pandemic:** An epidemic that has spread to more than one country

CHAPTER TWO: REVIEW OF RELATED LITERATURE

Ethiopia is one of the most populous countries in Africa standing third next to Nigeria and Egypt in that order. It has a population of about 70.7 million. Ethiopia stretches over a total area of land approximately one million square kilometers. Of this population, about 85% lives in the rural areas of the country (UNFPA, 2003). The majority of the population is very young among which 44% of the total population are children under the age of 15. Annual population growth is estimated at 2.7%. This trend leads to a population projection that will double in 30 years (CSA, 2003). The infant and maternal mortality rates are 97 and 188 per 1000 live births, respectively. Life expectancy at birth is 54 but could be lowered to 46 due to the high prevalence of HIV and AIDS. About half of the child population is underweight for their age and about half are stunted (MoH, 2003).

Over twenty years have been counted since the emergence of people affected by HIV and AIDS. The epidemic continues tragically snatching the lives of quite a significant number of our people. As a result, many children have been left without a father or a mother or both. These children are forced to live in a precarious situation where they are denied of the love, care, and support of their biological parents.

According to ICRW (2003), despite the growing body of knowledge, there is still a dearth of studies to help us understand HIV-related stigma and evaluate community-based interventions that address stigma, either as an issue in its own right or as a critical components of other HIV/AIDS programming. We also lack rigorously tested and widely accepted indicators to measure stigma in developing country contexts, which are needed to assess the extent of the problem in a given locality and evaluate our efforts to reduce stigma. It aims to disentangle the complex elements of stigma and

the social processes through which it occurs and to identify entry points for interventions.

Research shows that this internal stigma is manifested in many ways including self-hatred, self-isolation and shame. The ultimate effect of stigma, as noted by Goffman (1963), is the reduction of the life chances of the stigmatized through discriminatory action. Therefore, we do not consider, in this study, discrimination as a stand-alone concept or in isolation from stigma; rather, we take it as the end result of the process of stigma.

Examining the experience of other countries and related studies on HIV and AIDS establishes the basis for this study. How scholars in the area view and perceive HIV and AIDS-related stigma and discrimination needs to be thoroughly discussed. Therefore, the study attempts to incorporate, here in below, the available materials that have been in the reach of the researcher.

2.1 Policies and Legal Frame Work Regarding Children

A study noted the difficulty to categorically partial out the attitude of the society towards children whose parents died of AIDS. Through discussion, however, with all groups of the community, deep-rooted discriminatory attitudes towards PLWHA and orphaned children were underscored. Because there is nobody to take care of AIDS orphans, most of them are considered to be ill mannered and thieves (Haileyesus Getahun et al. 2002). A strong prejudice results among the public due to misconception and poor awareness about HIV and AIDS which eventually leads to discrimination which is, in turn, linked to violation of the rights of children i.e. not to be discriminated in any form as stipulated in article 2 of the CRC (1989). The article states:

"State parties shall respect and ensure the rights set forth in this Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's legal guardian's race, color, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status."

The 1990 African Charter on the Rights and Welfare of the Child, too, contains exactly the same statement. It has also to be noted that both the Convention and the Charter have been incorporated into the Ethiopian Constitution.

Though the available literatures show the complex nature of HIV and AIDS, they fail to describe how the virus marginalizes children associated with it from enjoying their rights. For example, the illness or death of a mother or caregiver during a child's first year jeopardizes the fulfillment of that child's basic needs, such as access to adequate nutrition, health care, and sanitation, which is usually a threat to their needs for survival. HIV and AIDS deprives of children's rights to grow in a family environment which is crucial and fundamental for their over all development. HIV and AIDS not only causes the death of caregivers, it also causes stigma which can put children at risk of stigma and discrimination, further isolating them from others at a time when they are most vulnerable and need as much care and support as possible. There are also false assumptions applied to this group, including that they are themselves infected. They lose out an opportunity to participate in their community, religion, cultural activities, and sports (UNICEF, 2005).

Being cognizant of the fact that children need, on one hand, the care and support of adults, on the other hand, the prevention from and protection against all forms of abuse, exploitation, neglect, and other forms of maltreatment, the member states of the United Nations almost

unanimously adopted the Convention on the Rights of the Child in 1989 that came into force in 1990. Ethiopia has also ratified and made the Convention law of the country in 1991. This Convention lays its foundation on several conventions designed to protect and benefit human beings on our planet. For instance, the 1948 Universal Declaration of Human Rights; the 1966 International Covenant on Civil and Political Rights (UN); the 1966 Economic, Social and Cultural Rights (UN) are some of the fundamental human rights instruments. All of the above covenants incorporate articles, which safeguard human beings from discriminations emanated from anything.

Children, thus, being members of the human society, are entitled to equally share all international as well as national human rights instruments. In addition to this, they also enjoy the special child right instruments designed particularly for them. According to the CRC, children have the right to be provided with basic requirements for their survival, growth, and development. Their physical needs that include food, clean water, clothing, shelter, fresh air and sleep, education and a supportive home environment have to be met accordingly. The CRC also outlines the following needs as essentials for their over all development:

- Protection from abuse and neglect
- Protection from all forms of exploitation
- Access to health and health services
- Access to appropriate information
- Privacy
- Freedom of association and expression of opinions
- Participation in recreation, play and cultural activities
- Leisure and rest opportunities

This being the case, if HIV and AIDS affect a family, there is a high probability for the denial of these fundamental rights.

In addition to their physical needs, their psychological needs such as adequate care, attention, security, love, acceptance and understanding have also to be met as well. HIV and AIDS evokes stigma upon the orphans that may eventually be manifested as discrimination, rejection, and isolation.

It is evident that children are integral parts of a society. They socialize themselves through play, peer and gender identification all of which contribute to their growth and development. Play facilitates communication, stimulation and experimentation and provides an opportunity to explore growth through emotions (Makerere University, no date). But orphans are often denied of such opportunities due to the death of their parents.

In the Ethiopian situation, too, the 1995 Constitution of the Federal Democratic Republic of Ethiopia incorporates the core of the elements that are specific and relevant to the survival, care, support, development and protection of children. The Penal law, the Civil Law, and the Labor Law of Ethiopia contain quite a number of articles that protect and benefit children. Education policy, health policy and Social welfare developmental policy and similar other documents produce much and give rise to the well-being of children.

However, much has been left to do regarding the effective implementation of the rights of children. The HIV and AIDS policy attempts to address the problems of adults in connection with HIV and AIDS. The problems of AIDS orphans with particular emphasis on stigma and discrimination have not been adequately treated in this particular and similar other social policies. Knowing the prevalence of AIDS orphans as high as above, ten percent, the policies and other strategic plans have not been geared to fully address their problems. This situation has been

affirmed by a study conducted in Ethiopia, witnessed that there is a consensus that the current HIV and AIDS policy material fails to address the issue of AIDS orphans adequately (MOLSA, Italian Cooperation, UNICEF, 2003).

2.2 Characteristics of Stigma

Stigma has ancient roots and has been described as a quality that “significantly discredits” an individual in the eyes of others. To further elaborate, some scholars consider stigma as a label that causes certain people to be regarded as different, defective and set apart from the society. The phenomenon of stigma was brought to public attention in the writings of the famous sociologist known as Erving Goffman in the 1960s. Since then, it has been a concern of society and continues to be a major focus in various forums that deal with marginalized groups of society in the context of fundamental human rights.

HIV and AIDS-related stigma builds upon and reinforces earlier negative thoughts. People with HIV and AIDS are often believed to have deserved what has happened as a result of their doing something wrong. Self-stigmatization or a feeling of shame that people living with HIV and AIDS experience when they internalize the negative responses and reactions of others are evident.

A study on HIV and AIDS-related stigma conducted in four countries, Ethiopia, Tanzania, Zambia, and Vietnam, (Ogden and Nyblade, 2005,) categorized the forms and expressions of stigma into four, loosely defined groups such as: physical stigma which refers to forms of stigma such as marking and separating shared objects like eating utensils and clothes at home and isolating them from public places; social stigma that includes social isolation, loss of identity and role, and voyeurism; verbal stigma that holds the direct practice like pointing fingers, insulting, taunting, or

blaming, or more indirect practice like gossip and rumors; and institutional stigma that refers to differential treatment defined institutional setting that causes negative outcome to the person living with HIV.

However, according to other scholars, stigma manifests itself in several specific forms depending on the various cultures of a given society. The following are some of the common forms worth mentioning: Name calling, scapegoating, finger pointing, teasing, ridiculing, labeling, blaming, judging, suspecting, neglecting, rejecting, isolating, making assumptions, backbiting, rumor, gossiping, shaming, separating, not sharing utensils, hiding, staying at a distance, harassment, physical violence, abuse, self stigma, blaming and isolating oneself, stigma by association (whole family or friends also affected by stigma), stigma by looks/appearance, associated stigma (family and friends also affected by stigma) Ross and Sue (2003).

Self-stigma can lead to depression, withdrawal and feelings of worthlessness. It silences and saps the strength of the already-weakened individuals and communities, and causes people to blame themselves for their predicament. This has links to what some writers have called "felt", as opposed to enacted stigma, in that it affects primarily an individual's or community's feelings and sense of pride. Erving Goffman (1963), in his classic study on stigma related to mental illness, physical deformities and what were perceived to be socially deviant behavior describes stigma as "an attribute that is deeply discrediting" and results in the reduction of a person or group "from a whole and usual person to a tainted, discounted one". Furthermore, the stigmatized often accepts the norms and values that label them as having negative differences. As a result, stigmatized individuals or groups may accept that they "deserve" to be treated poorly and unequally, making resistance to stigma and resulting discrimination even more difficult.

Goffman (1963) as cited in Kathryn Green et al. (2003) also made a distinction between two types of stigmatized persons. One refers to a discredited person who assumes that a supposed undesirable characteristic is visible and known to others. This person's task is to somehow manage the tension associated with having this information known. The other refers to a discreditable person who assumes that the undesirable characteristic is not visible or known by others. This person may attempt to conceal the information from others. Alternatively, the discredited person, who wants close relationships, may decide to disclose the information to some people but not to others or the discreditable person may decide to tailor how much to tell about oneself to reduce the possibility of being rejected or hurting others.

The privacy and disclosure process consists of at least two individuals engaged in a social interaction, each with her/his own feelings, beliefs, attitudes, values, and expectations, and the behavior of both persons is affected by the social, psychological, relational, and physical, context. A person shares private information with another specific person or persons. This distinguishes self-disclosure from public disclosure. People do not indiscriminately reveal private information; for doing so would make them feel too vulnerable (Gilberto, 1976; Petronio, 2002 cited in Kathryn Green et al., 2003).

Parker and Aggleton as cited in ICRW (2003) suggest that stigma can become firmly entrenched in a community by producing and reproducing relation of power and control. Dominant groups to legitimize and perpetuate inequalities based on gender, age, sexual orientation, class, race, ethnicity etc use stigma. By doing so, dominant groups effectively limit the ability of stigmatized groups and individuals to resist because of their entrenched marginal status. Stigma linked to power and domination plays a key role in producing and reproducing relations of power in the society as a whole.

Ultimately, it creates, and is reinforced by, social inequality. It has its origin deep within the structure of society, and in the norms and values that govern much of every day life. It causes some groups to be devalued and ashamed; and others to feel that they are superior (UNAIDS, 2002).

In addition to an exercise of power, stigma can be a response to fear, risk, or a threat of disease that is incurable and can be deadly (Gilmore and Somerville, 1994) cited in ICRW (2003). The more rapid the spread of the disease and the greater the uncertainty of how the disease is transmitted is the more stigmatizing the response. Epidemics that present an overt threat to the values of a community are especially likely to evoke a stigmatizing response, as stigma is used to "enhance or secure social structuring, safety and solidarity or reinforce societal or community values by excluding divergent or deviant ones or individuals".

Stigma is also more evident when the condition is unalterable, incurable, severe, degenerative, and leads to readily apparent physical disfigurement or to an undesirable and unaesthetic death.

The late Jonathan Mann, former head of WHO's global program on AIDS, identified stigma as a 'third epidemic' early in the history of HIV (the first two being the hidden but accelerating spread of HIV and the visible rise of AIDS cases). He further reiterated saying that stigma, discrimination, blame and collective denial were potentially the most difficult aspects of HIV and AIDS epidemic to address, but also that addressing them was key to overcoming the problems (ICRW, 2003). Stigma still remains one of the most significant challenges in developing countries for all HIV and AIDS programs, across the prevention to care continuum. Stigma increases vulnerability to HIV and worsens the impact of infection. Fear of being identified with HIV keeps people from learning their status in connection with HIV, changing behavior to prevent infecting others, caring for people living with HIV and AIDS, and accessing HIV and AIDS services. In addition,

stigma intensifies the emotional pain and suffering of people living with HIV, their families and caregivers.

HIV and AIDS is incurable, degenerative, often disfiguring and associated with an 'undesirable death' (Nzioka, 2000) Cited in ICRW (2003). It is often incorrectly thought to be highly contagious and a threat to the community at large. The general population, and sometimes-medical personnel, are not well informed and lack a deep understanding of HIV and AIDS. It is no wonder, then, that HIV and AIDS-related stigma has been particularly challenging to tackle.

Goffman (1963) describes three general causes of stigma: physical deformities, moral transgressions, and membership of despised social groups, which is transmittable through lineage and can equally, contaminate all members of a family. People living with HIV and AIDS almost always are associated with the first two because of the physical manifestations of AIDS and the association of HIV with 'deviant' and 'immoral' behaviors (particularly sexual 'promiscuity' and intravenous drug use). In addition, many people living with HIV and AIDS are members of groups that are already socially marginalized, such as sex workers or prostitutes and the poor.

Stigma may not only manifest itself when someone demonstrates some kind of the characteristic that may elicit stigma and discrimination. It may also take place when a person may be associated with another person, object or an act that could be perceived negatively. The stigmatized person may even arise fear or disgust; but at least such an individual tends to be disliked and avoided. However, unjustified it may be to respond negatively to a person on the basis of stigma, it seems even less justified to respond negatively to someone who is simply associated with that individual. Neuberg and his colleagues (1994) as cited in Baron and Byrne (1997)

pointed out that many people are unfairly disliked and avoided (stigmatized) because of a wide variety of characteristics.

2.3 Characteristic of Discrimination:

Though discrimination cannot be treated in isolation from stigma, it is worthwhile to examine its relationship with it. Stigma is harmful since it can lead to feelings of shame, guilt, and isolation of people living with HIV and AIDS, and also because negative thoughts often leads individuals to do things, or omit to do things, that harm others or deny them services or entitlements. Families and communities may reject and ostracize those living, or believed to be living, with HIV and AIDS; such acts constitute discrimination and violation of human rights.

Discrimination occurs when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group. Because of the stigma associated with HIV and AIDS, and the discrimination that follows from, the rights of people living with HIV and AIDS and their families are frequently violated. This violation of rights increases the negative impact of the epidemic. At the level of the individual, for example, it causes undue anxiety and distress that are factors known in them to contribute to ill health. At the level of the family and the community, it causes people to feel ashamed, to conceal their links with the epidemic, and to withdraw from participation in a more positive social response. And at the level of the society, in general, discrimination against people living with HIV reinforces the mistaken belief that such action is acceptable and that those infected with HIV and AIDS should be ostracized and blamed. Such people are also segregated in schools and hospitals in a manner that demonstrates cruel and degrading conditions

Freedom from discrimination is one of the fundamental elements of human rights founded on principles of natural justice that are universal and perpetual. The principle of non-discrimination is central to the human rights thinking and practice. The United Nations Commission on Human Rights, in its resolution of 1999/49; 2001/51; 2002/47, has affirmed that discrimination on the basis of HIV and AIDS status (actual or presumed) is prohibited by existing human rights standards. It is, therefore, important to recognize the links between stigma, discrimination and human rights violation, for stigma, discrimination, and human rights violations are interrelated and they create, reinforce and legitimize each other. And thereby, they form a vicious circle (UNAIDS, 2002).

A study in two metropolitan cities of India revealed that among all health care professionals, both in private and public hospital, doctors demonstrate to discriminate most against HIV positive patients. According to the finding, discrimination is greatest even among senior doctors. They don't change their opinion even though they are well aware of HIV and AIDS situation. However, on the contrary, Ward boys can change their negative attitudes after training is given. For example, Negative attitudes towards HIV and AIDS patients was shown when one of the senior doctors was asked a question such that if you have two patients, one HIV positive and another HIV negative, and you have negative drugs, who will you try to save? His response was that he would try to save the negative one, for the positive patient would die in any way (Shalini Bharat, 2001)

Similar negative attitudes prevailed in families and schools of the same cities. In familial relationships- parental, spouse, or sibling- gender was significant factor determining the likely response. In this connection, daughters, wives, and daughter-in-laws experienced greater levels of discrimination and stigma than sons, husbands and sons-in-laws. The

impact of HIV and AIDS for most men was cushioned by their privileged position in the society while for women it was intensified.

In the United States of America, too, while some progress has been made in reducing HIV and AIDS-related stigma and discrimination, and while public support for discriminatory policies have diminished; stigma still persists and continues to undermine HIV prevention efforts. As a result, the committee for HIV and AIDS prevention believes that the protection of human rights, privacy, and equity continues to be a significant concern, and those concurrent efforts at the federal, state, and local level to remove or at least lessen the impact of stigma and discrimination are necessary.

According to a study conducted in Ethiopia, Tanzania, and Zambia regarding HIV and AIDS-related stigma, the experience of stigma and discrimination are markedly similar across the three countries. The stigma manifests itself in multiple ways and with variation from the overt and blatant to the more covert and subtle. Whether or not overt, the experience of stigma and discrimination take three broad forms. These are: stigma and discrimination against people living with HIV and AIDS that includes differential treatment, (gossip, voyeurism, and taunting), loss of identity and role, loss of access to resources and livelihood; internalized stigma of people with HIV and AIDS that includes internalized guilt and self-depreciation, despondency, despair and loss of hope, self-isolation, abandoning life aspiration; and stigma and discrimination against those related to or associated with PLWHA (secondary stigma), such as children, family, caregivers, health care workers and friends. Among these groups of the society, the most affected ones are children and other family members. Families, in particular, are stigmatized if one or more of the family members are living with HIV and AIDS (ICRW, 2003).

2.4 Prevalence of HIV and AIDS Orphans and its Impacts

It is all too well recognized that the HIV and AIDS orphan crisis is one of the greatest humanitarian and development challenges facing the world. In countries where the prevalence of HIV and AIDS is very high, the number of orphans is also alarmingly growing. In the years and decades ahead, the impacts of HIV and AIDS on children, their families, and their communities will grow far worse-expanding to dimensions difficult to imagine at present if the problems remain un-arrested by bringing about significant, positive changes in the global communities. For instance, it has been estimated that 38% of the children in Southern and Eastern African countries could be orphaned, by 2010, because of parental HIV and AIDS cases (AIDS UP-dates, 2003). The same document reveals a projected global estimates that by the year 2015, there will be 44 million orphans under the age of 15 (one in three under five) in 23 countries (30 million of these orphans live in 19 countries in Sub-Saharan Africa) of which some will be infected by the virus and most of them will have lost their parents to AIDS.

Among the worst consequences of HIV and AIDS, orphan hood is one. The loss of a parent for a child is considerably significant. Loss of a father usually means the loss of income and results in economic depreciation. According to the report of the MoH (2002), the number of maternal orphans under the age of 15 is estimated at 1.2 million in 2001 and projected to be 1.8 million by 2007 and 2.5 million by 2014 unless the trend of the epidemic is curbed through effective measures (HAPCO, 2003).

Orphans are part of all communities in our planet earth. In any society, though with different magnitude, there will always be children who have had the misfortune to lose parents. In many poorer countries, families routinely took in children from the wider family. The scale of AIDS orphaning is such that these coping mechanisms are collapsing in the low

or middle-income countries. This stress is evidenced in the growing number of street children around the developing world (Tony and Alan, 2002).

2.5 Coping with HIV and AIDS-Related Stigma and Discrimination

Research reveals that various forms of strategies may be taken by PLWHA and their HIV and AIDS affected family members so as to cope with the experience and impact of stigma; of which disclosure of HIV status that produces support and care from family, friends, support groups, counseling, and other services is one. On the contrary, denial, non-disclosure of status and hiding away the person living with HIV can be also one of the coping mechanisms. Joining with other PLWHA formally or informally, arranging a situation is another coping mechanism for people with HIV. Searching for comfort or explanations is another form of coping strategy. For instance, there are people with HIV who turn to religion and prayer for comfort, solace, and support. Those whose coping mechanism is searching for an explanation for HIV infection other than sexual transmission cling to alternative explanation such as witchcraft, as in Tanzania and being given HIV by god, as in Ethiopia (ICRW, 2003).

It is earlier mentioned that the vast majority of the children orphaned by HIV and AIDS pandemic will be in Sub-Saharan African countries where formerly the extended family could always be relied upon to take on the dependents of those who died. But today such situations have fallen apart tremendously. The continent's age-old traditional social security mechanism that has proved itself in being resilient to so many social changes is buckling under due to the unprecedented strain caused by the increasing number of AIDS cases (AIDS UP-dates, 2002).

In African countries that have had long, severe epidemics, AIDS is generating orphans so quickly that family structures can no longer cope. Traditional safety nets are unraveling as more young adults die of this

disease. Families and communities can barely tend for themselves, let alone take care of others (Tony and Alan, 2002).

Taking in orphans increases the demands of household resource. In societies affected by HIV and AIDS, many children live in households where their own parents are fostering orphans. For instance, in Buganda, southern Uganda, a study shows that a total of 342 non-orphaned children and 383 orphans were living in 152 households. In these families, there was distinction between levels of care given to orphans or to the guardians' own biological children. Therefore, all children suffer the same economic and other deprivations resulting from spreading resources more thinly as a coping response to the epidemic (Monk, 2000 cited in Tony and Alan, 2002).

2.6 HIV and AIDS Transmission

HIV and AIDS is unique in the sense that it seems to track the fault lines in our society and profits from the social flaws and weakness inherent in societies in transition. Stigma is particularly strong surrounding mother-to-child transmission. The very phrase "mother-to-child" itself may be stigmatizing as it puts all the responsibility of transmission on the mother and none on the father of the child. Stigma stops women coming forward to get them tested. It reduces their choices when it comes to health care and family once they are diagnosed as HIV positive and has a negative effect on their quality of life (AIDS-updates, 2003).

A number of scholars, as cited by Asnake Hailu (2001), have been the source of great fear and controversial issue (Royse, 1987). Rational and irrational assumptions and fears have pervaded all through societies (Denney and Quadagno, 1992). Many people today are doubtful about the transmission of HIV. For instance, Tsehaynesh and Solomon (1998) identified some misconceptions and speculations about HIV and AIDS transmission that points out saliva, body contact, and breath as the means

of transmission. Some people think saliva and tear toilet seats transmit the virus. Some others think mosquitoes inject the virus into some-ones blood so that infection may take place.

The creation of an environment in which the rights of PLWHA live is one of the fundamental measures that can significantly reduce the transmission of HIV. Such situation ensures the reduction of vulnerability to HIV and AIDS, for those infected with and affected by the epidemic live in dignity and with out discrimination (ONCHR & UNAIDS, 1998). This becomes a reality when widespread review or reforms of laws and legal support services, with a focus on anti-discrimination and protection of PLWHA and those most vulnerable to the epidemic is made. Areas that need legislative and health policy and standard revision in relation to HIV and AIDS include measures such as informed consent, partner notification, universal precautions, orphans inheritance, criminal laws, obligations of HIV-positive people, anti-discrimination laws, privacy and confidentiality, employment regulations, and HIV and AIDS goods and services (HAPCO, 2003).

2.7 Prevention Programs

The fear of stigma, in turn, impedes prevention efforts, including discussion of safer sex with one's partner, condom use, and preventing mother-to-child transmission. The existing strong beliefs about the association of HIV with "immoral" behavior make people dissociate themselves from "others" who they perceive engage in such activity. On the other front, the utilization of VCT services and disclosure of HIV status are constrained because of the anticipated stigma and the actual stigma experienced by people living with HIV (ICRW, 2003). Such situation jeopardizes the attainment of effective prevention undertakings.

If HIV/AIDS prevention programs are held in a standard of perfection are expected to prevent 100% of people from being infected 100% of the time. The efforts, with this principle, are by definition doomed to failure. No intervention aimed at changing behavior to promote health has been or can be 100% successful (AIDS-updates, 2003).

Considering the critical situation, the various United Nations organizations had designed a World AIDS campaign for the year 2002-2003 that focused on stigma discrimination and human rights. The main objective of the campaign was to prevent, reduce, and ultimately eliminate HIV/AIDS-related stigma and discrimination whenever it occurs and in all its forms that are triggered by many forces, including lack of understanding of the disease, myths about how HIV is transmitted, prejudice, lack of treatment, irresponsible media reporting on the epidemic, fears relating to illness and death (UNAIDS, 2002).

2.8 Psychosocial Impacts of HIV and AIDS-Related Stigma

It is globally believed that HIV and AIDS has personal, communal and social dimensions in that it affects us in every level of our lives and threatens to isolate us from the broader society. It negatively affects the demography of a country; children are being alarmingly orphaned, economies are severely challenged, human resources are drastically affected and social services are depleting. Lack of treatment facilities, unaffordable cost of treatments and drug and also lack of hospitals, home for the terminally ill, care and support units impose a further threat. The never ending misconceptions and false notions leading to stigmatization, discrimination and isolation of people affected with HIV and AIDS make it not only a health problem but also economic and social issues. AIDS systematically cuts down life expectancy and increases death rates in countries where the disease is rampant.

The impact of HIV and AIDS on mortality and the number of children orphaned by AIDS in Sub-Saharan Africa will continue to increase through the years 2010. Approximately 3.2 million children were orphaned in Sub-Saharan Africa in 1999. In 2003, about 5.2 million children became orphans in the region. A recent analysis made by UNICEF on caring practices in 40 countries in Sub-Saharan Africa show that extended families have assumed responsibility for more than 90% of orphaned children. An especially significant and distinctive characteristic of HIV and AIDS in regard to orphaning is that AIDS is more likely than other causes of death to create double orphans. It is all too well known that if one parent is infected with HIV, there is a high probability that the other parent is or will become infected and both will eventually die. This means, countries with high prevalence of HIV and AIDS will also have a disproportionate number of double orphans as the epidemic advances. Surveys consistently demonstrate that double orphans are more disadvantaged than single orphans. For instance, in Tanzania, the school attendance rate for children whose parents are alive and who live with at least with one of them is 71%, but for double orphans it is only 52% (UNAIDS, UNICEF, USAID (2004)

HIV and AIDS have also economic implications as well as impact on the life of each human being in the society. For example, in Ethiopia, life expectancy, which was 50.9, with out AIDS, in 1998, has gone down to 40.9 as a consequence of AIDS. This is again estimated to be 38.6 in 2010 unless the country takes serious measures to arrest the HIV transmission. To compare our situation with the neighboring country, Kenya, life expectancy that was 65.6, with out AIDS, in 1998, has gone down to 47.6 as a consequence of AIDS (Shalina Mehta, Suninder K.Sodhi, 2004).

No other infectious diseases of the modern era have had such a devastating impact on the world's youngest and most vulnerable citizens as HIV and AIDS. One of the most telling and troubling consequences of the

epidemics growing reach is the number of children it has orphaned or seriously impacted. While the impact of this loss of life differs across families, communities, and societies, one thing is clear: a child's life often falls apart when he/she loses a parent.

In most cultures, children who are either HIV-positive, or associated with an adult who is HIV-positive or who died of AIDS routinely face discrimination from their peers, their guardians, their teachers, and from the community in general. Consequently, they may be barred from schools, harassed by peers, and even may be prevented from joining others in peer activities (Brown and Sittitri, 1995 cited in Abebe, 2000).

Africa is a home to 95% of the children orphaned by HIV/AIDS. In the past, the sense of duty and responsibility among extended families in Africa was almost without limits. Even when a family did not have sufficient resources to care its existing members, orphans were taken in. The extended family support network functions through changes in household composition; relatives move into households to care for children who survive their parent's death, or orphans move into households of one or more relatives in response to the overwhelming demands of the epidemic. But the extended family is not a social sponge with an infinite capacity to soak up orphans. Today, this traditional safety net is becoming saturated, overwhelmed, and weakened by a combination of three factors: a huge increase in the number of orphans, a significant decrease in the number of prime-age caregivers, and a systematic change to the social structure that underpins the traditional safety net (Max Essex et al., 2002).

Estimates for 26 African countries suggested that the number of children, below the ages of 14, who are paternal orphans or maternal orphans from any cause will be more than double between 1990 and 2010. However, this fails to reveal the true extent of the number of children affected by HIV and AIDS, for the estimate exclude children between the

ages of 15 and 17, a group with the highest orphan rate. This exclusion significantly underestimates the total orphan number by 25% to 35%.

The Declaration of Commitment, adopted by the United Nations General Assembly Special Session on HIV and AIDS in June 2001, highlighted global consensus on the importance of tackling the stigma and discrimination caused by HIV/AIDS. All over the world, shame and stigma associated with the epidemic have silenced open discussion, both of its causes and of appropriate responses. This has caused the infected with and the affected by HIV and AIDS to feel guilty and ashamed, unable to express their views and they fear that they will not be taken seriously. HIV and AIDS-related stigma and discrimination have powerful psychological consequences in that they lead such people to depression, lack of self-worth, and despair. The situations make them also undermine prevention mechanisms, for they refrain from finding out whether or not they are infected, for fear of the reaction of others if they do so. The document further reiterates that stigma, silence, discrimination and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations (*ibid*).

AIDS deaths often have a greater impact on livelihoods than deaths by other causes because they usually occur earlier and after a long period of illness and decline and because they are often associated with illness or death of the spouse.

Orphaned children risk poor socialization, poverty, and lack of education, as well as sexual and physiological abuse. Inevitably, many orphaned children will grow up at high risk of HIV themselves, especially girls, who are more likely to be withdrawn from education when household resources are squeezed (Foster, 2000 as cited in Karen, 2002). Direct evidence from orphaned children in Zimbabwe suggests that both sexes

may experience low self-esteem, isolation, stigma and discrimination (Karen McElrath, 2002).

It has to be recognized that there is variation in the negative impact children orphaned due to AIDS and non-AIDS orphans encounter. Unlike orphans due to other factors, HIV and AIDS orphans are often stigmatized and blamed by family members, school mates, and the community members around them. People believe that the HIV infections are caused by adultery their parents involved in. At times the orphans are abused verbally, physically, and sexually. These orphans may consider living on the street as an alternative to run away from the sufferings they face at home. Prostitution, for girls, could also be taken as source of income for their sustenance which could, through time, make them contract HIV and AIDS (ICRW, 2003).

Separation: When helping a child who faces a loss or separation from parents due to death, it should be remembered that the first thing to emphasize is that some one will take care of him/her, preferably specifying who the caregiver will be. Then let the child know (1) that the dead person did not choose to leave him/her; (2) that the dead person can never return; and (3) that the person's body is to be buried in the ground (Claudia Jewett Jarratt, 1994). In doing so, however, adults have to device appropriate ways to tell about such things in a style tailored to a particular child's age and capacity to comprehend may avoid significant troubles later.

Relatives or guardians often separate siblings following the death of their parents so as to share more easily the burden of care. Sometimes, it may not be possible to place orphaned siblings with relatives or one foster family. Now that is a natural tendency for orphaned children to be grieving about the death of their parents, subsequent separation from their siblings compounds their feeling of loss. Adolescent girls may be "pawnd" sent to a relative or neighbor to work in return for money paid to the fostering family.

Children especially those under five may be fostered, while older siblings are left to live by themselves.

Families dealing with HIV/AIDS often keep it a secret that remains within the family because of the social stigma surrounding the disease. Mothers in particular, are concerned about confidentiality because they fear the impact of AIDS stigmatization on their children's well being (Gorna, 1996 cited in Carol A. (1999).

Children who slip through the safety net often end up in a variety of vulnerable situations. Rising numbers of households headed by orphans sometimes as young as 11 and 12 are recent phenomenon. Rising number of orphaned children living on the street, working children, the children removed from school to provide care giving or labor are all indicators of stress on the safety net.

In many AIDS affected communities, mechanism that keeps families and households from destitution comprises material relief, labor, and emotional support provided by community members. It is obvious that relief is primarily sought from relatives, friends of parents, neighbors. The progressive, wide spread of AIDS leads to adverse impact upon the economy of families and communities. In connection with, economic factors are crucial to determining how the extended family will provide care for its orphans.

Migration of orphans may also occur due to economic factors. Urban-rural relocation is often spurred by the onset of serious illness, in the so-called going-home to-die syndrome. Children affected by AIDS are particularly likely to be relocated before or following a parent's death. In order to generate income, adolescents leave orphan households to seek work. Some girls become involved in commercial sex work or enter into marriage as girl-brides to provide for the needs of younger children in their

households. Children who live on the street are significantly more likely to be orphans. This seems true because, currently, the number of street children is considerably increasing; one of the factors for the increase being poverty associated with HIV/AIDS. One less obvious economic impact of the epidemic has been an increase in child labor, sometimes involving children as young as five (Max Essex et al., 2002).

A study of households in Uganda indicates that among children between the ages of 15 and 19 whose parents had died, only 29% continued their schooling without disruption, 25% lost school time, and 45% dropped out of school altogether. (ibid) Some non-governmental organizations in the two Indian metropolitan cities where a study was conducted acknowledged schools as a setting for HIV/AIDS-related stigma and discrimination. Problems both for HIV positive parents and positive children were beginning to be observed at the time of the study. In Mumbai, one HIV positive couple, and one widow of a man who had had AIDS were forced to withdraw their HIV negative children from school. School management offered no specific reasons and the affected parents were too afraid to pursue the matter in one case, reluctant to have their identity become known to others (Shalini Bharat, 2001).

Orphans are less likely to have proper education. The death of a prime age adult in a household will reduce a child's attendance at school. When a child goes to another household after the death of his/her parents, the obstacle become greater as the child is not their own (World Bank, 1997 cited in (Tony and Alan, 2002). For instance, in Zambia's copper-belt, an area badly affected by HIV and AIDS, it was found that 44% of the children of school going-age were not attending school, but with proportionately more orphans (53.6%) than non-orphans (42.4%) not attending (Rossi and Reijer, 1995 cited in Tony and Alan, 2002).

Enrolment rates varied with households' assets, but they also varied with the gender of the deceased parent. To cite an example, in Zambia, 99% of children attending schools prior to the death of the mother, the enrolment rate fell to 87% (80% in urban areas and 93% in rural areas) after the mothers' death. When a mother died, children were expected to take on more domestic work to replace her labor contribution. Even those attending do so less frequently (Mutangadura, 2000 cited in Tony and Alan, 2002). Girls carry a larger burden of domestic responsibility than boys and are more likely to be kept out school.

Even if the orphans manage to go to school their attendance will be less consistent, their progression rates will be more erratic and their academic attainments and results will be poorer. This is true whether they are living in an affected households, are orphaned and taken in by others, or orphaned and living on their own.

Health and Nutrition: A survey in Zimbabwe and Tanzania, shows that orphans were more likely to be stunted in their growth than non-orphans, but more likely to be wasted (Max Essex et al., 2002). When the problems are seen from economic dimensions, AIDS deaths often have a greater impact on livelihoods than deaths by other factors, because breadwinners of the family are snatched away. The general situation indicates that Aids affected households tend to be poorer, consuming less food and with smaller disposable incomes; it is hardly surprising that children in these households are usually less well-nourished and have a greater chance of being stunted which has a long-term effects on the over all development of children. Developmental foundations are poorly built with poor physical condition, compromised immune systems and mental functioning. This will, in turn, affect the ability of children to benefit from education and to function socially, and economically later in their lives. It can affect a society for a generation or beyond that (Tony and Alan, 2002).

In a survey study there appears variation in the impact resulted from the death of a mother and a father. For example, a study in Malawi revealed that young children whose mothers had died were 3.3 times more likely to die compared to children of mothers who did not die. Maternal death, from whatever cause, results in higher mortality among children. Thus, the health and life situation of any woman is crucial to the health and life chances of their children, not only during pregnancy but also throughout the entire childhood. A mother's capacity for child care, the time and energy she can devote to her children, the conditions at home, her material resources, her skills and knowledge, continue to govern a child's passage from childhood to maturity, socially, physically, and emotionally (Mutangadura, 2000 cited in Tony and Alan, 2002)

Psychological Impact: Where basic needs are not met, it is difficult for agencies to concentrate on addressing psychological needs. Sometimes the fulfillment of psychological needs may be less pressing in the absence of meeting the basic needs such as food, clothing, and shelter. In certain instances, a blanket and food may be more appropriate than counseling.

However, it is undeniable fact that the impact of HIV and AIDS on households leads to sequential trauma associated with continuous traumatic stress syndrome. Separation of siblings is a major factor contributing to psychological distress among orphans.

The impact of AIDS on children in both developed and developing countries is essentially without difference; with most children showing psychological reactions to parental illness and death. A child's psychological health depends to a large extent upon the status of his or her parents. Signs of mother's depression, guilt, anger, or fear may be realized though not understood and may then become reflected in children as changed behavior. Orphans most often say they miss the love of their parents and their families. A study in Zambia shows that parents noted that children

became worried and sad, and that they tried to help more in the home and stopped playing so as to stay nearby. Children in households affected by HIV and AIDS were more likely to become solitary; to appear miserable or distressed, and to be fearful of new situations than were children in the household not affected by the epidemic.

Stigmatization, discrimination, social isolation, dropping out of school, moving away from friends, and bearing an increased workload in the home all heighten the stress and trauma that accompanies the death of a parent. Stigmatization based on orphan status or poverty rather than parental HIV status is common as is also associated with adverse mental health.

A study in Uganda shows that children expressed feelings of hopelessness or anger when their parents became sick and feared that their parents would die. Most orphans were depressed and had lower expectations about the future. Depression was highest among those between the ages of 10 and 14. Children showing these symptoms were more likely to be living with a widowed father than with a widowed mother. This in turn suggests that the loss of a mother is more distressing than the loss of a father. Orphans were found to internalizing behavior changes, such as depression, anxiety, and decreased self-esteem, rather than to exhibit acting out or socio-pathic behavior such as stealing, truancy, aggression, and running away (Max Essex et al., 2002).

2.9 Countering HIV and AIDS-Related Stigma and Discrimination

Various types of approaches have been employed to tackle HIV and AIDS related problems particularly stigma and discrimination in countries where the problems are of much concern. Despite two decades of public education, prevention efforts, and passage of protective legislation, AIDS-

related stigma continues to be a serious problem (Herek, 1999 cited in Monica S., 2001).

To eliminate HIV and AIDS-related stigma and discrimination, policy and legal reform will have a limited impact unless supported by the values and expectation of a society as a whole. Widespread and enduring changes in social attitudes are required if we are to make headway against HIV and AIDS-related stigma and discrimination. Bringing about significant changes in the society requires all stakeholders including people living with and affected by HIV, partners, children, families, religious leaders, opinion leaders, legal and civil rights groups, non-governmental groups as well as community-based organizations, business community, and labor organizations, doctors, nurses, health-care workers, politicians, teachers, youth leaders, women leaders, community workers, the police and the army. In addition, links and coordination need to be made with broader struggles that address the underlying economic, social, cultural, and political inequalities (*ibid*).

By employing different approaches some countries have attained success in countering HIV and AIDS-related stigma and discrimination. In Zimbabwe, for example, combining information-based approaches with counseling has brought about increased disclosure among people living with HIV and AIDS, and has triggered improved community attitude (Kerry, 1996 cited in UNAIDS, 2002). In Uganda, the work of the AIDS Support Organization (TASO) and other community-based groups have been central to encouraging greater openness about the epidemic and in providing support and care to individuals, families and communities living with HIV and AIDS (Kaleeba, N et al, 1997 cited in UNAIDS, 2000). In Thailand, multi-sectoral work bringing together a range of government and non-governmental organizations was key to reducing new infections in the badly affected area like Phayao province in the late 1990's and promoting good-

quality home-and community-based care. A people- oriented approach facilitated greater openness about the epidemic and the promotion of a "care not scare" approach reportedly stimulated greater social cohesion and support

(<http://www.unaids.org/publications/documents/care/general/una004e.pdf>).

The care and support that PLWHA needs, often require to be provided intensively for an extended period of time. This care may come with stigma in that PLWHA get the care and support from their families and health care providers. The care and support of Families may be accompanied with judgmental attitudes about the potential mode of transmission. Families may withdraw from providing medicine, food, and other amenities because of the common perception people with HIV are hopeless and near death. In an extreme sense, the denial of care can result in abandonment. Poverty also exacerbates denial or withdrawal of care and support.

Discriminatory care and support for PLWHA in health care centers is exhibited in the form of longer waits for services, being shuttled from provider to provider, not being given treatment or equal care to those with other illness and being scolded by providers. For example, in the three sites, Ethiopia, Tanzania and Zambia, while most doctors do not report treating their patients with HIV and AIDS any differently than other patients, several clients do report receiving less aggressive treatment than an HIV- negative patients (ICRW, 2003).

An adequate response to the AIDS has to encompass and address issues of individual and community mental health. The impact of the virus may be direct (for example, living with HIV) or indirect (nursing some one with AIDS). The impact is felt on people living with HIV and AIDS, their kin, friends, and colleagues. It crosses generations. Children not only feel the direct impact but their nurturing also suffers. Blame and other

manifestations of stigma serve to compound the psychological impacts of trauma (UNAIDS, 2005).

Regarding the prevention efforts exerted, in Ethiopia, the strategic plan prepared by HAPCO in 2004 for the years 2004-2008, highlights a range of achievements and weaknesses registered in the country. Some of the achievements include:

- An increased level of awareness and positive trends in behavioral change
- An increased demand for voluntary counseling and testing (VCT)
- An increased trend in condom distribution and utilization
- Integration and expansion of VCT
- Initiation of prevention of mother to child transmission (PMTCT) and anti retroviral (ARV) services
- Positive trends in openness and reduction of stigma and discrimination

HAPCO, having said this, uncovered the challenges and weaknesses the intervention programs encountered in the process of implementation. It recognizes that the national response and intervention are still far behind compared to the magnitude of the problems.

CHAPTER THREE: DESIGN OF THE STUDY

The researcher, considering the issue under study as seriously sensitive, decided the research tools to be used in a manner that ensure confidentiality, privacy and security. The approach for the data collection has been planned to be participatory by involving older AIDS orphans who were in senior high schools as data collectors.

Thus, the following approaches and procedures were thought to be appropriate to carry out this particular study.

3.1 Research Methods

The study had been conducted employing descriptive research method. The data collection procedure was designed to be participatory where orphans at senior high school level or who completed high school education were selected as data collectors. The intention of such practice was to create opportunities for the target orphans to air out their feelings attitudes to their peers openly.

They were 38 in number out of which 19 were female and 19 male. Sixteen (8 female and 8 male) of the data collectors were selected from Addis Ababa while 10 (5 female and 5 male) were from Nazareth. The remaining 12 (6 female and 6 male) were selected from Awassa. This was done purposefully, because the researcher thought that the orphans might feel free to express their opinion without inhibition, for they are all orphans. Not only were they orphans but they were also gender friendly in that female data collectors were assigned to collect from female orphans while male were assigned to collect from male orphans. The reason for this was that female children could do better with female respondents and male could do the same with male respondents. All of them took training as to how to approach the subjects and kick off the question and answer in their

respective localities. The training also helped them to get clarification about doubtful questions. Data has been also obtained through focus-group discussions as well as interviews that had been conducted by the researcher himself.

3.2 Data Collection Instruments

The data collection process took place using two types of questionnaires with both open-ended and closed-ended question items. One of the questionnaires was prepared having 52 question items for AIDS orphans whereas the other was prepared having 24 question items for people working with HIV and AIDS orphans in selected non-governmental organizations with a view to obtain supplemental information that could be used for verification. The later questionnaire attempted to see issues related to stigma and discrimination from the organizations' perspective. A pilot test was conducted in Addis Ababa by distributing 20 questionnaires in order to make amendments.

A focus group discussion guides with structured and semi structured questions were prepared. They were all prepared to be employed in the discussion to be held, on one hand, among the orphans, and on the other hand, among other relevant people involved in matters pertaining to HIV and AIDS. Semi-structured interview questions had been also designed for key informants regarding matters pertaining to HIV and AIDS-related stigma and discrimination.

3.3 Setting Organizations and Participants

The sample size set for the study consisted of 402 AIDS orphans who had been systematically selected from eight non-governmental organizations operating in three major cities of Ethiopia, namely, Addis Ababa (Addis Ababa City Administration), Nazareth (Oromia Region), and

Awassa (Southern Nations, Nationalities, and peoples Region). The cities were purposively selected, because these cities are among the places HIV and AIDS tremendously affect in the country. The purposive selection of the organizations mainly focused on these cities because they provide care and support services for many AIDS orphans. The names of the selected organizations and the sample size which were taken in proportion to the size of the given population in each organization were: Mary Joy with a sample of 124 orphans (62 female and 62 male), ISAPSO with a sample of 10 (5 female and 5 male), Progynist with a sample of 13 (6 female and 7 male), and Tesfa Birhan with a sample of 11 (5 female and 6 male) from Addis Ababa (Addis Ababa Administration); OSSA with a sample of 81 (41 female and 40 male) and FORUM on Street Children-Ethiopia with a sample of 30 (15 female and 15 male) from Nazareth (Oromiya); and, Mary Joy with a sample of 105 (52 female and 53 male) and OSSA with a sample of 28 (14 female and 14 male) from Awassa (SNNPR). The researcher decided to have equal number of female and male orphans proportional to the size of the population in the respective organizations. Taking this into consideration, the researcher took lists of names of the AIDS orphans from each of the identified organizations. On the list, those female and male orphans with the age of 7-17 were identified. Regarding their age, 17 have been considered as the upper limit, for a person over this age is no more a child according to the CRC. The sample size was determined to be proportional to the total size of the population in each organization. Female and male AIDS orphans were systematically clustered in each organization. From each sex group, the samples had been picked up randomly depending on the size of the population. Luckily enough, the name list of the orphans also provides the address of each child, which helped the data collectors to locate the residence of the selected orphans. To this effect, Simple random sampling technique had been employed.

The study, in addition to the orphans, includes the staff members of the organizations mentioned above. Sixty-seven staff members took part in filling out the questionnaire prepared for them.

3.4 Data Collection Procedure

The study targets HIV and AIDS orphans who are registered in selected non-governmental organizations operating in Addis Ababa, Nazareth and Awassa. The orphans include those between the ages of seven and seventeen. The rationale for considering seven years as a bench mark for the lower age limit is that a child at this age and above may be mature enough to discuss with others about issues concerning her/him. Another factor is that primary school age starts at seven. Therefore, these children can understand and express what happens at home, at school and in the community. Moreover, children of this age may freely, without fear, express their feelings verbally and easily communicate with others.

All experts and practitioners working with such orphans in their respective organizations are also included as source of information. People living with HIV took part in the study as resource persons in matters pertaining to HIV and AIDS-related stigma and discrimination in up interviews. '*Idir leaders*' who are highly involved in mobilizing the community in cooperation with the selected NGOs participated in the FGD conducted in all the study areas. Associations of people living with HIV and AIDS contributed a lot by providing important information for the study. An association of young AIDS orphans also produced adequate data in connection with the experiences of its orphan members. In this regarding, focus group discussions (FGD) were conducted with one group selected from different organizations including: *idir* leaders working with Mary Joy in Awassa and Addis Ababa, Forum on Street Children in Nazareth; FGD with staff of Tesfa Birhan, an association of AIDS orphans, AIDS orphans in Mary Joy of Addis Ababa, orphans of OSSA in Nazareth; and with women

group who are PLWHA, of Tila an association of PLWHA in Awassa. Regarding group interview, one group interview with three mothers living with the virus, each bringing their small children with them, had been conducted.

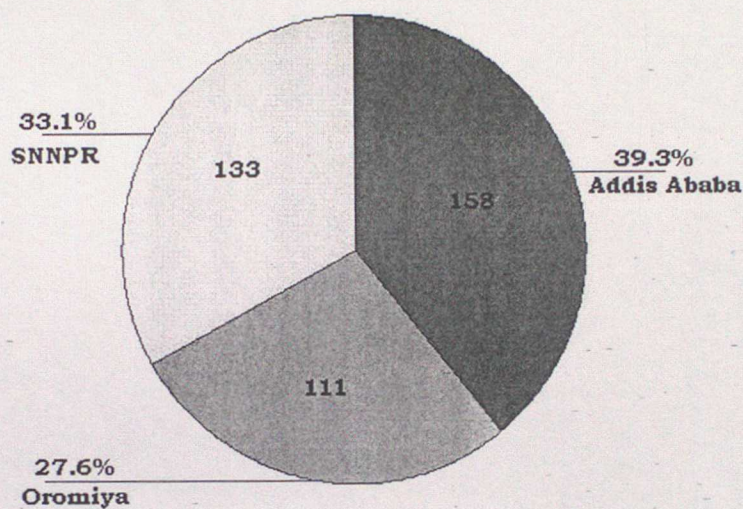
3.5 Methods of Data Analysis

The data, after being collected, was entered and computed in SPSS statistical package. Because the data was collected using questionnaire prepared in Amharic language, it was translated into the English version In order to facilitate the statistical process. Then, analysis of the collected data has been made using quantitative, inferntial and qualitative research techniques.

CHAPTER FOUR: FINDINGS AND DISCUSSIONS

The information gathered is presented in charts and tables as in the following manner. Following the charts and the tables, discussions and analysis are made on the basis of the data obtained and within the frame of reference of the set objectives.

Figure 1: Number of respondents by region



The target population has been selected from Addis Ababa Administrative Council, Oromiya and Southern Nations, Nationalities and Peoples regional states as displayed in figure 1 above. The cities selected in these regions are among the places in the country where the effect of HIV and AIDS epidemic has been highly felt.

Figure 2: Number of respondents by city and sex

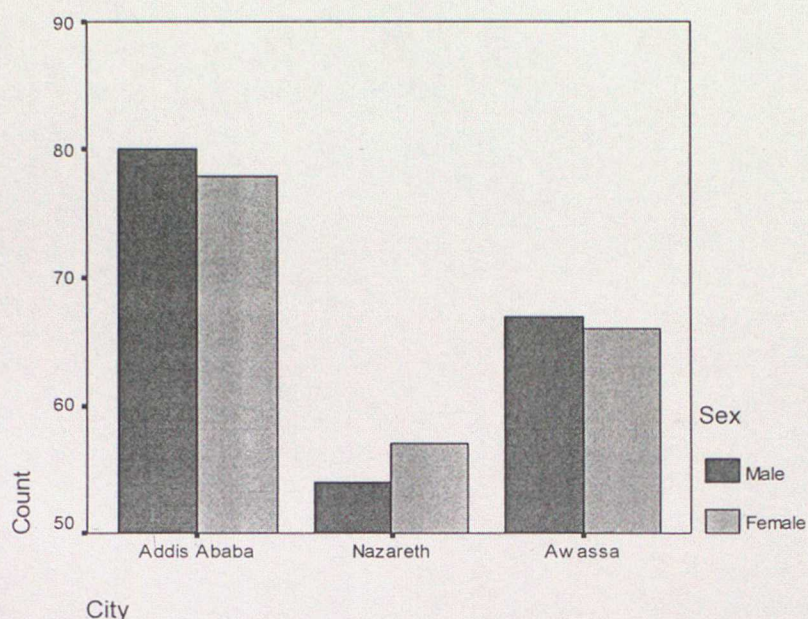
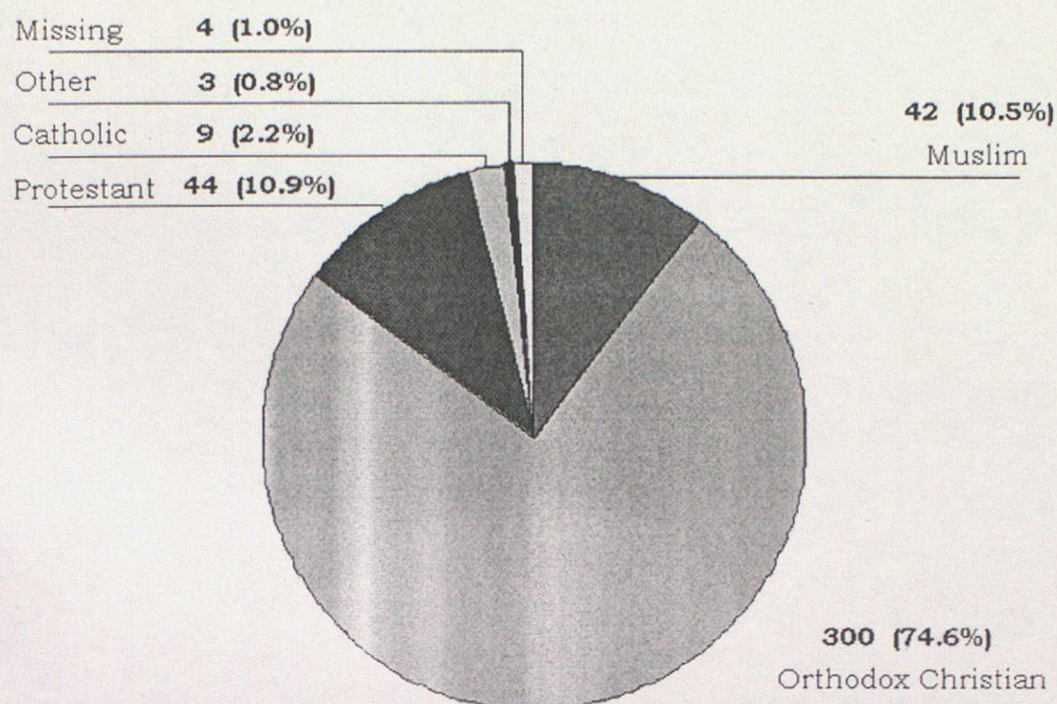


Figure 2 presents the distribution of AIDS orphans according to their sex distribution in each city. The sample selected includes those AIDS orphans only from the cities illustrated in chart one above. AIDS orphans in any other parts of cities of the regional states have not been included in the sample under study. The total number of AIDS orphans in Addis Ababa equals to 158 out of which 78 are female and 80 male. Nazareth has a total of 111 AIDS orphans out of which female orphans constitute 57 and male 54. From a total of 133 orphans in Nazareth, 66 account for female while 67 make up the male orphans. The female and male samples are almost equal in size but with insignificant variations.

Figure 3: Distribution of respondents by religion



The number of the orthodox Christians is predominantly the biggest constituting 300 or 74.6% of the total respondents. A share of 42 (0.4%) consists of the Muslim group, while 44 (10.4%) contains the protestant followers, nine (2.2%) are the catholic followers and the remaining three (0.7%) belongs to the 'other' response items. Finally, four or 1.0% of the respondents have not mentioned any thing regarding their religion and are taken as missing.

Table 1: Distribution of respondents by age

Age range	Frequency	Percent	Valid Percent	Cumulative Percent
5 - 9	63	15.7	15.8	15.8
10 - 14	239	59.5	59.9	75.7
15 - 19	97	24.1	24.3	100.0
Total	399	99.3	100.0	
Missing System	3	.7		
Total	402	100.0		

The Central Statistic Authority has formulated this age range and has been applying it for many years now. Majority of the respondents falls in the age range of 10-14. It should be noted that the lower limit of the range does not include age 5 and 6, for the target population excludes them. Similarly, the upper limit of the age range does not include age 18 and 19 because of the fact that by the time a person reaches the age of 18 she/he attains the age of majority (adulthood), which has not been target of the study.

The age range from 10-14 embodies 239 respondents, which comprises 59.9% of the total respondents while 97 (24.3%) of the respondents lie in the age range of 15-19. The remaining 63 (15.7%) are in the age range of 5-9.

However, according to Claudia Jewett Jarratt (1994) whatever their age may be, orphans need authentic empathy, respect, and support from caring adults. Orphaned children could be at risk of seeing themselves as unlovable, unwanted, and unworthy.

Table 2: Distribution of respondents by nationality and region

Response	Region			Total
	Addis Ababa	Oromiya	SNNPR	
Gurage	26	5	10	41
Amhara	56	60	45	161
Wolaita	5	-	29	34
Oromo	54	37	24	115
Sidama	-	-	7	7
Tigrai	7	6	9	22
Other	7	2	9	18
Total	155	110	133	398

According to table 2 the total number of the respondents of all nationalities in the three cities accounts for 398. It also illustrates the number of orphans in some of the regional states in the country. The greatest majority consists of 161 orphans of the Amhara nationality. The second majority appears to be 115 orphans of the Oromo nationality which appears slightly lower in number than the former. The remaining 4 orphans did not tell either their nationality or region or both. Other wise, the total figure would have been 402.

Table 3: Distribution of respondents by lost parents

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Father only	123	30.6	30.8	30.8
Mother only	28	7.0	7.0	37.8
Both are lost	248	61.7	62.2	100.0
Total	399	99.3	100.0	
Missing System	3	0.7		
Total	402	100.0		

Among the orphans, as shown in table 3, who lost both parents (double orphans) accounts for a considerable majority, 248, of the aggregate respondents. It embraces 62.2% of the total respondents. Those who lost only their father consist of 123 (30.8%) of the orphans. The remaining 28 (7.0%) represent those groups of orphans who lost their mothers only. Despite this, the lose of a parent, one or single, seriously affects every aspect of a child's life such as their emotional well-being, physical security, mental development and over all health conditions (UNICEF, 2005). In the same document, Kifle, A. (2002) mentioned that among the child laborers he interviewed, more than three quarters were orphaned, though no mention of the cause for the loss, out of which 80% of them had no right to leave the job whenever they want and many of them worked more than 11 hours a day. They remained with no opportunity to education, leisure and recreation. Thus, significant numbers of children face such challenges of life in their years of development. Among the total respondents 99.3% are likely to suffer from the loss of one or both parents.

Table 4: Distribution of respondents by current school enrollment

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Government school	309	76.9	77.3	77.3
Private school	46	11.4	11.5	88.8
Religious school	13	3.2	3.3	92.0
Dropout	7	1.7	1.8	93.8
Never enrolled	3	.7	.8	94.5
Other	22	5.5	5.5	100.0
Total	400	99.5	100.0	
Missing System	2	.5		
Total	402	100.0		

Government schools enrolled 309 (77.3%) of the orphans in the available space. Only 46 (11.5%) of the orphans joined the private schools, which have been thought to be providing better education with appropriate facilities. It is a common practice in Ethiopia that parents who can afford to pay for the education of their children do send them to private schools. The private schools usually have classrooms with small size and relatively faire teacher-student ratio. But it is significantly the opposite in government schools. Classes are full to the brim with children. In the FGDs, all *idir* leaders agree that in government schools with a class size of over 90 students, effective teaching may be impossible. In another FGD with the orphans themselves, it has been pointed out that children were worried about their education in the following year; because they have information that as of the year 2006 and starting from grade five media of instruction for all subjects will be English. So, due to their low level of communication skills in English language, they are afraid of coping up with the change. They confirmed that the reason for their weakness in effectively using the English language was that they do not have chances to practice drills in classrooms. Neither do they take homework because of their big class size. Their teachers cannot manage to follow up the learning situation of students. Measurement and evaluation activities could not be undertaken in classes. Participatory learning-teaching practice may be unthinkable. Thus, the finding demonstrates that it is likely for the orphans to end up in government schools, which are the only affordable schools for those who can't afford. Because of such situation the orphans are denied of getting quality education.

The number of drop out and who have never enrolled appear to be 7 (1.8%) and 3 (0.8%) respectively. Though these figures add up to 10 (2.4%) of the total respondents, relatively speaking, this might be insignificant compared to the existing dropouts and out-of school children in the country.

However, luckily enough, 92.0%, of the respondents attend school. Nonetheless, it should be noted that the finding, in this regard, does not show or represent the reality of the current situation of orphans in the study areas. It so happened simply because the study samples have been taken from those groups of orphans that were registered by the target NGOs of the selected cities.

The relatively significant reasons for the dropout and for the non-enrollment were mainly poor economic situation, death of parents, and ill-health of parents as presented in descending order. Three mothers, in a group interview, described stigma and discrimination as one of the major reasons for dropping out of school. One of the mothers said,

"My husband died to AIDS a year ago, 2004, leaving behind two baby girls. The younger one was five years old. The elder one was seven years old. For fear that I may be contracted with the virus; I went to a clinic for check up. I was diagnosed HIV positive. My husband was the only breadwinner by working as a guard in a private company. His monthly income had been barely enough to take us a month. When he died, my daughters and I ended up in an empty house. Let alone paying for a house rent, earning daily bread became practically impossible. One day, one of my friends advised me to open up myself as HIV positive and teach the community. She told me that if I do so, an NGO named, wegen lewengen, would pay me birr 400 every month. I did it as I was told and secured the money.

However, the whole situation, regarding my children, particularly my younger daughter, turned into a devastating direction. One of her schoolmates who knew the entire story about me disseminated the information among the class children. She started suffering from her

classmates' interrogation and inquiries whether she had the virus or not. Not able to with stand the new incidence, one day she came home weeping and asked me, 'what does AIDS look like?' Being totally upset I couldn't give her the proper answer. After a while, I told her that AIDS looks like a toy. But she couldn't be convinced. Finally, she refused going to that school. Whenever I asked her to go to she always cried. I took her out of school and tried to enroll her in another school. Finally, she declared that she will never dare to go to any school. So, she is not at school currently. Thus, I regret the disclosure of my HIV atatus that had been, in fact, resulted from my desolation. Poverty compelled me to do things that I wouldn't have done other wise."

This scenario indicates that the reality on the ground seems quite different from what has been told about the attainment of attitudinal changes in the society in connection with stigma and discrimination. It is generally accepted that poverty is a common factor that marginalizes quite many children of poor families from getting education and other social services. However, the very fact that they are AIDS orphans coupled with poverty, may aggravate the disastrous effects of the situation. In addition to their unfulfilled needs due to poverty, they may encounter stigma and discrimination associated with HIV and AIDS.

Table 5: Distribution of respondents by current educational grade level

Response	Frequency	Percent	Valid Percent	Cumulative Percent
1 - 4	158	39.3	40.4	40.4
5 - 8	196	48.8	50.1	90.5
9 - 12	34	8.5	8.7	99.2
Higher institution	2	0.5	0.5	99.7
Other	1	0.2	0.3	100.0
Total	391	97.3	100.0	
Missing System	11	2.7		
Total	402	100.0		

The classification of the educational grade level from primary educational level to higher institutions has been taken from the Ministry of Education. Out of the total number of orphans enrolled in both primary and higher institutions, 90.5% are in the two educational cycles, grade 1-4 and grade 5-8 of the primary educational level. There appears to be 158 (40.4%) are in the first cycle while 196 (50.1%) are in the second cycle of the primary educational level. This situation could be considered as relatively fair compared to their age in that most of the children seem to be in their appropriate age for these grade levels. However, the high school enrollment status does not show reasonable number of children. Only 34 (8.7%) of the total orphans are in grades 9-12. Sad enough, two (0.5%) attend higher education, which is almost nothing. This may reflect the general educational status of orphans, which shows that there would be stumbling block for most marginalized children that hinder them from completing high school education and joining higher institutions. The data collection for this study had been conducted indiscriminately by giving equal chance for all orphans age 7 to <18. The data collectors might have captured quite a large number of orphans had there been many high school children as there had been in the primary schools. So, it seems impossible to imagine the

happening of such things to be a coincidence. There should have been fairly a large number of children at grades 9-12 by the age of about 16 and 17 which seems incompatible in this case.

Table 6: Distribution of respondents by age and participation in classroom activities

Age	Always Participate		Rarely Participate		Never Participate		No chance for participation		Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
5 - 9	31	19.6	28	13.0	1	16.7	1	50.0	-	-	61	15.9%
10 - 14	92	58.2	129	59.7	4	66.6	1	50.0	1	33.3	233	60.5%
15 - 19	35	22.2	59	27.3	1	16.7	-	-	2	66.7	91	23.6%
Total	158	100.0	216	100.0	6	100.0	2	100.0	3	100.0	385	100.0

Regarding participation in classroom activities 158 respondents said that they always participate in classroom activities in their respective schools. Out of these respondents 19.6% belongs to the age range 5-9. The greater number of respondents, 58.2%, falls within the age bracket of 10-14 while the remaining 22.2% belongs to 15-19. Among those, 216 orphans, whose response have been rarely participate 13% were in the age range of 5-9, while 59.7% were in the age range of 10-14. The remaining 27.3% were housed in the age range of 15-19. In this case it should be noted that the numbers that appear in this table could be misleading in that the participation level seems increasing as the ages of the orphans increase. But the reality has been far from what it appears in the same table. To see the relationship between the increase in the ages and the level of participation, the respondents who appear in each category of age range should be compared with the actual or total number of orphans housed in each age range as shown in table 1.

When the data is examined in this frame of reference, the number of respondents who always participate appears to be considerably higher than the number of respondents who rarely participate. The distribution of the respondents in relation to the response "always participate" seems to be fair compared to the number of the total orphans in each age range as shown in the respective rows of table 1. When respondents, 31, are compared with 63, which represents the total number of orphans in the age group of 5-9, those who always participate comprise 49.2%. When 92 is compared with 239, in the age range of 10-14, the number of respondents who always participate becomes 38.5%. Considering the age range of 15-19, and comparing 35 to 97, which holds the total orphans within the given age group, only 36.1% constitute those who always participate.

Regarding the response item, "rarely participate", on one hand, the number of participants out of 63 orphans, in the age group of 5-9, constitutes 28 (44.4%). On the other hand, Out of the total number of orphans, 239, within the age bracket of 10-14, the respondents are 129 (54.1%). Among the respondents, 97, within the age range of 15-19, those who participate consist of 59 (60.8%).

However, in all age categories, 5-9, 10-14, and 15-19, there exists variation in the level of participation. Nearly half of the orphans always participate in school activities in the case of the first age range, while a bit less than half of the orphans do the same in the second age range, 10-14. But in the age range of 15-19, out of 97 orphans 35 (36.1%) always participate. The active participation rate in this case seems a bit higher at early age, 5-9, than at later ages when they are close to the age of puberty and adolescence. This might be due to the reason that areas of interest other than classroom activities might preoccupy them. Their attention might be diverted to various personal concerns. As the ages of the orphans grow, their inclination to participate in classroom activities seems to have

been going down. These might be due to, among other causes, the depression and distress they might have had developed as a result of loss of their parents.

In the case of rare participation, though it is obvious that children are attracted by other factors, their response shows that they don't totally abandon their school activities. They disclosed that they participate on and off with an increasing rate. Regarding the response item, "never participate", only six respondents were available following the response pattern that has been seen in each age category. The figure compared to the total number of the respondents, as mentioned by a few orphans in the FGD, the reason for their not participating in classroom activities were that, in one way or another, there had not been inviting environment that could encourage them to participate.

It is worth mentioning in this context that the discriminatory environment seems less, for the classroom situation is mostly managed and controlled by teachers. Peer groups in classroom atmosphere may not highly put their influence and pressure. Most of the children can have an environment conducive for participation in classroom activities.

Children who have lost their parents may become convinced that they have done something awful or disgusting or disgraceful, and this leads them to an additional blow at a time when they need and deserve reassurance that they are worthwhile and acceptable people. Their schoolmates, fearing that they, too, could suffer a similar catastrophe, may avoid them, and the resulting social isolation is likely to cause them to behave in ways that annoy or irritate others, which in turn isolates them all the more. They become more and more withdrawn, develop ever more serious behavior problems, or fall even farther outside the community's

pale, where they may become scapegoats or the subjects of classmates' rejection and ridicule (Claudia Jewett Jarratt, 1994).

A study in Botswana pointed out that educational performance, generally, goes down immediately after the death of a parent. Some orphans demonstrate depression while some others become fine. But, orphans from low socio-economic background appear to have problems at educational performance and classroom participation (Tony Barnett and Alan Whiteside, 2002).

In this research, a great majority of the orphans are from low income families that do not encourage them to be physically and mentally active, it follows that some of the respondents are likely to have less participation in class room activities.

Table 7: Distribution of respondents by age and participation in sports activities

Age	Always Participate		Rarely Participate		Never Participate		Nobody gives me chance		Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
5 - 9	18	11.5	32	19.5	9	14.7	1	14.3	2	66.7	62	15.9
10 - 14	102	65.4	97	59.2	32	52.5	4	57.1	-	-	235	60.1
15 - 19	36	23.1	35	21.3	20	32.8	2	28.6	1	33.3	94	24.0
Total	156	100.0	164	100.0	61	100.0	7	100.0	3	100.0	391	100.0

The natures of activities that are to be performed in sport settings are much more different from the classroom situation. A total of 156 respondents pronounced that they always participate in sport activities out of which 11.5% belong to the age group of 5-9 while 65.4% to the age group of 10-14. The remaining 23.1% are member of the age group of 15-19. The answers that are given to this response item shows that quite a large number of orphans actively participate in sport activities. Relatively

speaking, proportional size to the total population of the respondents in the age group of 15-19 takes part in sport activities.

Concerning the answer item "rarely participate" 164 respondents have been identified, among which 19.5% fall in the age range of 5-9, and 59.2% in the age range of 10-14 whereas 21.3 are in the age range of 15-19. This category of the respondents indicates that a large number of them participate in sport activities, though with a limited scale. Likewise, with the increase of their age, the number of participants increases. As it has been substantiated in the literature, it is a natural tendency that such children may not be interested to take part in activities that involve large number of people with whom they do not feel comfortable. Some may isolate themselves thinking that others do not accept them. Some may think others may despise them.

Contrary to these two responses, a total of 61 respondents declared that they never participated in sport activities. Out of this, 14.7% are in the age bracket of 5-9, while 52.5% are in the age range of 10-14. The other group, 32.8%, belongs to age range of 15-19. The age distribution in this category, too, follows the same pattern as seen in the other two categories in such a way that as the age of the children increases the number of participants also increased. Participants in an FGD with children agree that some orphans do not like to join others in sport activities because some children at times show a feeling of discomfort, some even stop playing when AIDS orphans join them.

Table 8: Distribution of respondents by age and participation in school clubs and other activities

Age	Always Participate		Rarely Participate		Never Participate		No clubs		Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
5 - 9	5	6.9	6	9.8	31	16.0	15	34.1	4	28.6	61	15.8
10 - 14	39	54.2	38	62.3	125	64.4	23	52.3	7	50.0	232	60.3
15 - 19	28	38.9	17	27.9	38	19.6	6	13.6	3	21.4	92	23.9
Total	72	100.0	61	100.0	194	100.0	44	100.0	14	100.0	385	100.0

As table 8 makes it plain, out of a total of 385 respondents 72 said that they always participate in school clubs out of which, 6.9% are in the age range of 5-9, while 54.2% are in the age bracket of 10-14, and the remaining 38.9% are placed in the age range of 15-19. Only very few respondents in the age group of 5-9 take part in school clubs. This may witness that according to the tradition of most schools in Ethiopia, children of this age bracket may hardly be members of school clubs.

In the case of answer items 'rarely participate', a total of 61 respondents placed themselves in it out of which 9.8%, 62.3%, and 27.9% belong to the age range of 5-9, 10-14, and 15-19 in that order. In this answer item, too, the number of respondents has a similar pattern as it is seen in 'always participate' answer item. In here again, only a few respondents declared their rare participation.

Regarding the other answer item, 'Never participate', a total of 194 respondents declared that they never participate in school club activities. Out of this, 16%, 64.4%, and 19.6% belong to the age group of 5-9, 10-14, and 15-19 respectively. Quite a significant number of respondents admitted that they never participate in school club and other activities. This could be attributed to discrimination and stigma emanating from the misconception

about the transmission of HIV and AIDS. For instance, a research finding conducted in North Wollo attested this by mentioning the misconception of the society about the transmission of the virus: "It is believed that being in the same classroom with PLWHA can transmit the disease. Children therefore, face discrimination in the school" (Haileyesus Getahun et al. 2002).

To further elaborate, an informant in an interview said:

"In 2004, a 15 year old student of grade 8 in Addis Ababa who lost both parents became HIV positive. His aunt took care of him and he was and is still comfortable with her. But he is not always happy with the school environment. The school expelled him for no apparent reason but seemingly for fear that he would transmit the virus to others. When the director of the school was asked about the expulsion, he did not tell the reason clearly, rather he explained that the child should be placed under the close follow up and care of a family in a nearby school to his residence. His aunt, then, had to change her residence to kaliti area due to her own reasons. So, she placed him in a school around her new residence. But he still felt discomfort and did not want to participate in any school activities. He always appeared depressed. In the end, he, on his own, left the school and ended up in a drop out."

This demonstrates that children refrain from participation due to many reasons that may affect them psychologically. Particularly, if they sense a sign of stigma they could fall into a worse situation.

A total of 44 respondents said that they have not been participating because there are no clubs in their respective schools. Therefore, the total

respondents who never participated in school activities become less by 44, which accounts for a total of 150.

Table 9: Distribution of respondents by disliked teachers by the orphans

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	87	21.6	22.4	22.4
No	301	74.9	77.6	100.0
Total	388	96.5	100.0	
Missing System	14	3.5		
Total	402	100.0		

Out of the total number of respondents, 388, who attempted to answer this question, 22.4% said that there are teachers whom they disfavored much while 77.6% said that they haven't had such teachers. Among the reasons reflected by those respondents who dislike their teachers are: the teachers use down grading words against them, annoying words, scolding them, battering them , look down on them, showing grumbling behavior and the like. Such feelings of the respondents may reveal their sensitivity to these types of behavior manifestations. The orphans also revealed that this happened on them as a consequence of their being orphan.

The manifestations of these types of behavior may be a common practice faced by almost all children whenever they are together and they may not take it seriously under normal circumstances. But in the case of the AIDS orphans, the impact may be different. They could sense it associating with the death of their parents, which had initially been associated with HIV and AIDS. For example, an informant substantiated this notion by telling what she had observed while performing her duties in

Addis Ababa. She was a community worker on HIV and AIDS for an NGO. The story goes:

"An eight year old boy was a student in Kazanchis area. He lost his parents due to AIDS when he was eight years old. His father's sister agreed to take care of him though she had financial limitations. Once he became sick and the informant facilitated his medical treatment. Some how, the community worker learned that the child was HIV positive. She shared the information with his aunt for the purpose of precaution. She also gave proper advice to the lady as to how she can manage the whole situation. One day the boy told his aunt that the teacher ordered him to put on hand gloves while learning and playing for no apparent reasons. Being amazed to hear that, the community worker asked the teacher how he happened to say that. The teacher said that he knew that the cause for the death of the parents had been HIV and AIDS. He further mentioned that he has a fear that the boy always scratches his body; he may bleed and may transfer the virus to his classmates. Then the child started digging out what is happening around and finally he ended up in dropping out of school. When the boy was asked the reason why he left school; he said that he doesn't want to see his teacher. But at the same time he refused an offer to join another school because he wants it."

The reason for his refusal to join another school could be that the same discrimination may follow him; or he might become hopeless because he will die some time in the near future. Thus, one can see and imagine the problems with complex nature he has been faced with. Many of the participants in each FGD had similar stories but with different settings and conditions.

Table 10: Distribution of respondents by classmates disliked by the orphnans

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	105	26.1	27.1	27.1
No	283	70.4	72.9	100.0
Total	388	96.5	100.0	
Missing System	14	3.5		
Total	402	100.0		

This table shows that a total of 388 expressed their feelings about their classmates. Out of the total respondents, 27.1% reveal that there are classmates whom they dislike while large majority of the respondents, 72.4%, tell that they don't have disfavored classmates. Some of the common reasons which the respondents gave for their hatred are such that the classmates tease them, make others laugh at them, insult them, hate them for no apparent reasons, batter them and the like. These groups of children seem to be sensitive to such behavior manifestations of their classmates. A mother of a six -year old female child and living with HIV told us in a group interview that her child always said that she doesn't like to see her kindergarten class mate named Abenezer. But she never explains to her mother the reason why? Simply she tells she dislikes him very much. The mother suspecting the reason for her daughter's dislike said that the boy might have insulted or teased her in connection with my HIV positive status. She also mentioned her child, at times, used to repeatedly ask her how AIDS makes me different from others. According to the mother it seems that her child has some kind of her own understanding about HIV and AIDS. She suspects her child visualizing or imagining the virus in a certain kind of shape that only she can understand.

Usually, whenever children gather, some of them may demonstrate these types of behavior. However, the perception and the reaction of each

child to such behaviors may not be similar. Whatever the case may be, the effect on the AIDS orphans could be quite different from that of non-orphans feel for the very reason that the orphans may think that it happens because of the death of their parents due to AIDS.

Table 11: Distribution of respondents by age at the time of the death of parents

Response	Frequency	Percent	Valid Percent	Cumulative Percent
0 - 4	85	21.1	21.6	21.6
5 - 9	181	45.0	46.1	67.7
10 - 14	58	14.4	14.8	82.4
15 - 19	9	2.2	2.3	84.7
I don't know	60	14.9	15.3	100.0
Total	393	97.8	100.0	
Missing System	9	2.2		
Total	402	100.0		

Out of the grand total of the sample, 402, a total of 393 could tell the level of their ages when their parents died. 21.6% of them were in the age range of 0-4 by the time when they lost their parents. Almost half of the respondents, 46.1%, had been in the age range of 5-9 at the time of their parents' death. The other groups that comprise 14.8% were in the age bracket of 10-14. A study conducted in Uganda pointed out that depression was the highest among those between the ages of 10-14 (AIDS in Africa, 2002). 2.3% were in the age limit between 15 and 19. Quite significant number of the respondents, 15.3%, does not know how old they were when their parents died. This could imply that there is no one concerned about these children. No one dared to inform their age of that time. From this one can understand the situation they are in and the status of the care and support they receive.

When one examines the cumulative effect of this finding, 67.7% of the respondents were below the age of nine when they lost their parents. Children, below the age nine, do not understand what death exactly mean. They only understand that they are just separated from their families and they think of their coming back. They appear to be looking forward to seeing their parents some how. Children acquire a more mature understanding of death starting from age nine. They realize that death is the irreversible end of life as they know it and that they themselves will eventually die (Claudia Jewett Jarratt, 1994). This shows that they lost their parents when they were at their critical and formative age. Families are fundamental units of the society for the over all development of children. Scholars categorize these ages of the human life in which the social and cultural practices of the society are inculcated and internalized. Moreover, 82.4% of the respondents are found below age 14, which is again a time where these children attend primary schools. The presence of their families at these times of their age is crucial for the overall development of the children. But as the given literature shows, the very younger children are more affected than the older children by the loss of their parents, for the latter relatively easily adjusts to the new situation realizing that death is a natural phenomenon while the former ones think of seeing their parents again. Various types of negative behavior may develop until such time that they realize such things would never happen.

Table 12: Distribution of respondents by causes for the death of parents

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Tuberculosis	95	23.6	24.0	24.0
Accident	20	5.0	5.1	29.0
Drought	31	7.7	7.8	36.9
Unknown	125	31.1	31.6	68.4
Other	50	12.4	12.6	81.1
HIV and AIDS	59	14.7	14.9	96.0
I don't know	16	4.0	4.0	100.0
Total	396	98.5	100.0	
Missing System	6	1.5		
Total	402	100.0		

For the question set forth to enquire the causes for the death of parents, 24.0% of the respondents said tuberculosis, while 7.8% said drought both of which, in most cases, have strong link with HIV and AIDS. Only 14.9% of the respondents said HIV and AIDS was the cause for the death of their parents. Fairly larger proportion of the respondents, (31.6%), said that the cause has not been known. A total of 5.1% attribute the death of their parents to accident, which, in some instances, may be far from being linked to HIV and AIDS. Another 12.6 attribute the death of their parents to different causes, which are housed in the answer item of 'other'.

In view of the given responses one can understand the issue of HIV and AIDS has still remained a hidden agenda. In an interview, an informant said, "My organization posted a notice that invites all 'AIDS orphans' in the community for registration. But nobody appeared. The following time they made the announcement again; but with out mentioning AIDS and simply writing 'orphans' only." This time over one hundred orphans appeared out of which almost all happened to be AIDS orphans. This had been attested in

an FGD with *idir* leaders. Participants witnessed that AIDS orphans do not like to be registered as an AIDS orphan; they would rather prefer to be identified simply as an orphan. This situation confirms the fear of stigma is still prevalent.

This illustrates conformingly the level of disclosure in the study areas. It goes with out saying that the society, unless in the form of gossip, never openly discuss about HIV and AIDS. Children have never been told about the death of their parents to AIDS. This, in turn, makes them keep the issue secret. The true nature of this situation had been substantiated in all focus group discussions and interviews.

Table 13: Distribution of respondents by having siblings

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	309	76.9	77.8	77.8
No	88	21.9	22.2	100.0
Total	397	98.8	100.0	
Missing System	5	1.2		
Total	402	100.0		

Greater majority of the respondents, 77.8%, mentioned that they have siblings out of which 79.4% live together with their siblings, while the remaining, 20.6%, live separated from their siblings. Separation is always a tragic situation in which most orphans encounter. The situation in the case of AIDS orphans most difficult because their problems will be coupled with stigma and discrimination resulted from HIV and AIDS. The loss of parents coupled with separation from siblings can aggravate the psychological problems of the orphans. However, the level of their age may determine the magnitude of their feelings towards the separation and the associated stigma. As Claudia Jewett Jarratt (1994) suggested it is a little easier to tell children about loss if one understands that children take in, think about,

and absorb information differently from adults and that the way they process it changes as they get older. Something that might make perfect sense to a nine-year-old could leave a five-year-old lost and confused. Devising ways to talk about things in a style tailored to a particular child's capacity for understanding may avoid significant troubles later. Thus 20.6% of the orphans are likely to suffer separation from siblings.

Table 14: Distribution of respondents by current caretaker

Response	Frequency	Percent	Valid Percent	Cumulative Percent
1. My relatives	71	17.7	17.8	17.8
2. My parent's friends	6	1.5	1.5	19.3
3. Our neighbors	8	2.0	2.0	21.3
4. My brother	16	4.0	4.0	25.3
5. My sister	21	5.2	5.3	30.5
6. Myself	15	3.7	3.8	34.3
7. An organization	31	7.7	7.8	42.0
8. Mother/Father	82	20.4	20.5	62.5
9. Grand Parents	61	15.2	15.3	77.8
10. 1 & 7	83	20.6	20.8	98.5
11. Other	6	1.5	1.5	100.0
Total	400	99.5	100.0	
Missing System	2	.5		
Total	402	100.0		

Children after the death of their parents, their destination has commonly been moving to other places for care and support. They may be placed in a family who are either biologically related or who are non-relatives. As one can see in table 14, there appear various types of families who accommodate the orphans. Relatives, grand parents, relatives and organizations combined provide care and support to 17.8%, 15.3% and 20.8% of the orphans in that order. Those who secure care and support from mothers or fathers constitute 20.5%. Of all these groups of care

providers the heaviest burden of responsibilities rests upon grand parents; for it would be too difficult for them to take care of their grand children due to the infirmities of old age. The *idir* leaders in the FGD in Adama mentioned that four children had been left with too old grand father who could not even support himself. He had no income of his own. He sustained with the occasional support of philanthropist individuals in the neighborhood. After the orphans came into him, all of them starved to death. So, considering the disastrous situation of this family, the *idir* of the neighborhood took the responsibility of supporting and caring for the children with the cooperation of NGOs.

In the focus group discussion that comprised of *idir* leaders, in Awassa, the participants witnessed that many grand parents take care of their grand children orphaned due to AIDS. For example, a very old grand mother who had no reliable income for sustenance had to care for two grand children about a year ago. Seeing the suffering of this family, women's *idir* took over the responsibility of supporting them by renting a house and voluntarily contributing money from all women.

These participants mentioned that who suffer most are those orphans whose parents have not been member of the *idir*. It is difficult to register such children. Nobody knows their background. And no one can give testimony about their loss of parents due to AIDS.

Table 15: Distribution of respondents by demonstration of caretakers love to all children in the family

Response	Frequency	Percent	Valid Percent	Cumulative Percent
They cuddle me as they do to their children	105	26.2	38.6	38.6
They pay me less attention than they do to their children	50	12.4	18.4	57.0
They are indifferent to me	58	14.4	21.3	78.3
Other	59	14.7	21.7	100.0
Total	272	67.7	100.0	
Missing System	130	32.3		
Total	402	100.0		

The question in this table has been forwarded to see the level of love and affection given to the orphans by the families or guardians who have their own biological children. Out of the total number of the samples, 402, who live with families or guardians having their own biological children were 272. The remaining 130 orphans have not been living with families or guardians having their own biological children. Out of those 272, the number of respondents used to enjoy as equal treatment as children of the families constitute 38.6%. Families or guardians of 18.4% of the respondents appear to be less attentive to the orphans under their custody. The other group of families or guardians was indifferent to 21.3% of the orphans. The remaining 21.7% of the respondents encounter various forms of treatment in terms of love and affection in their families or guardians. Thus, one could see that all orphans in all the three groups of families or guardians live in unfavorable environments. Such living conditions could not be free of discrimination, neglect and rejection. As long as they are in situations where equal treatment does not prevail, it becomes highly probable that they are in a discriminatory home environment.

UNICEF (2005) affirmed such hard fact by a statement that goes, children in households affected by AIDS or who are living with HIV may still be stigmatized or they may end up in being mistreated, in a situation of abuse and neglect by their foster families or may have to endure separation from their siblings. Fore example, in a focus group discussion, one of the participants said that an 11-year old female child had been living together with her elder brother and she was supporting him by selling boiled cereals on the streets of Nazareth. Another 13-year old female child participant of the group discussion said;

"My mother died earlier than my father. After the death of my father, his sister came and took me from my stepmother saying that she will rear me better than any body else. She also said she would provide me with all the comforts. My aunt had a husband and two children of her own. The family did not have a housemaid. After I got there, I had to take care of the domestic chores that should have been performed by a housemaid. Her children had opportunities to study and play but I was allowed neither to play nor to study. Because of the heavy workload, I never had time to study my lessons and do homework. I was better off when I was living with my stepmother. She was sympathetic and generous."

The other group discussants also mentioned that some families take in orphans not because out of their empathy, rather for the purpose of exploiting their labor in the guise of the provision of custody. Some families do not treat the orphans as they treat their biological children. In the FGD undertaken in Adama, one of the participants raised a case of a seven-year-old child. The story goes:

"A woman got a boy child by her husband who had been a carpenter. She died when the child was three years old. The maximum amount of his monthly income could not be more than birr 400, which was relatively sufficient enough for the sustenance of the family when his wife was alive. He later married another woman and got a girl child by the new wife. By the time the child became seven years of age, the father died leaving the child with the stepmother. So now, the step mother makes this seven year old child carry her four year old child."

Still another 10-year old AIDS orphan participant said that she has a younger sister of eight years of age who was hired in a rural household. Their aunt with whom this orphan lives collects the salary of her sister; and they don't know what she uses the money for. They also mentioned that an 11-year-old boy has to fetch water at least once a day by rolling a barrel full of water for the family he lives with. This information is self explanatory in that the exploitation of orphans by others including their relatives takes many forms.

**Table 16: Distribution of respondents by current family dining.
practice**

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Each member dines individually	107	26.6	30.3	30.3
The entire family dines together	147	36.6	41.6	72.0
Every child dines individually while parents dine together	41	10.2	11.6	83.6
Children dine in a separate group while adults dine in another group	33	8.2	9.3	92.9
Other	25	6.2	7.1	100.0
Total	353	87.8	100.0	
Missing System	49	12.2		
Total	402	100.0		

Table 16 shows the dining practices in most families. Out of the total respondents, 30.3% revealed the practice in such a way that every member of the household dine individually while 41.6% indicate that the entire family dine together. In the family of 11.6% of the respondents, every child dines individually while parents dine together. Children dine in a separate group while adults dine in another group in the families of 9.3% of respondents.

In this particular case those respondents who belong to the answer item, 'other', 25 (7.1%) have expressed various forms of dining practices in their families of which a few are worth noting. Among those 25 individual orphans 12 respondents said that they are served individually in isolation while their biological children dine together. The reason behind this may be

the fear that their children could contract HIV and AIDS when dining together. When an AIDS orphaned child is served with food individually while their biological children are served together the reason behind is likely to be discrimination. What else could such practice be other than segregation? Whatever the case may be, in one way or another, these children are discriminated. This being the case, though the number of respondents in this regard seems to be small, the issue associated with HIV and AIDS is a serious one and one should not ignore it.

Table 17: Distribution of respondents by practice of using separate utensils

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	59	14.7	15.0	15.0
No	334	83.1	85.0	100.0
Total	393	97.8	100.0	
Missing System	9	2.2		
Total	402	100.0		

In table 17, 15.0% of the respondents said that they have separate utensils that they use only for eating and drinking. The remaining confirmed that they don't have any utensil specifically marked only for them to eat and drink. Though the number of orphans that covers those who have utensils specially marked for them only seems small compared to those who have not, it indicates the prevalence of stigma and discrimination in these households. The respondents that consist of 59 (15.0%) is quite significant to show the prevalence of stigma and discrimination. In this case, it should not be the size of the number that matters, rather it should be the impact, which would result from the practice on the orphans that should count. In expressing the reason for such practices the children said that it was because, " they were not my parents, they suspect me as HIV

positive, fear of HIV and AIDS transmission, my frequent sickness.” Thus, these children have different perception about their exclusion; the situation indicates that they experience an environment of discrimination.

Table 18: Distribution of respondents by family monthly income

Response In birr	Frequency	Percent	Valid Percent	Cumulative Percent
Less or equal to 100	171	42.5	43.7	43.7
101 - 200	56	13.9	14.3	58.1
201 - 300	12	3.0	3.1	61.1
301 - 400	5	1.2	1.3	62.4
401 - 500	3	.7	.8	63.2
501 - 600	1	.2	.3	63.4
601 - 700	1	.2	.3	63.7
I don't know	142	35.3	36.3	100.0
Total	391	97.3	100.0	
Missing System	11	2.7		
Total	402	100.0		

Regarding current family income, 43.7% of the respondents declare that their families' monthly income has been less or equal to birr 100, while 14.3% of the respondents claim to be in the range of birr 101-200. Close to the same number, 36.3% of the respondents state that they don't know the monthly income of their families. The finding in the table displays that majority of the respondents are from low-income families. From this reality one can consider that the needs of the children have been far from being met. This trend also shows that most of AIDS orphans come from low-income families.

Table 19: Distribution of children's opinion on adequacy of food they get

Age	I always get		I get sometimes		I never get		Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
5 - 9	22	16.9	28	15.8	7	8.1	1	25.0	58	14.57
10 - 14	84	64.6	99	55.9	65	74.7	3	75.0	251	63.10
15 - 19	24	18.5	50	28.3	15	17.2	-	-	89	22.36
Total	130	100.0	177	100.0	87	100.0	4	100.0	398	100.0

Out of the total of 398 respondents 130 stated they always get sufficient food, of which 16.9% were in the age range of 5-9; while 64.6% were in the age range of 10-14; and the remaining 18.5% were in the age range of 15-19. Another group of respondents, 177, said that some times they get sufficient food to eat; out of which 15.8% belongs to the age group of 5-9; and 55.9% belongs to the age range of 10-14 and 28.3% to the age range of 15-19.

Still another group of respondents constituting 87 reflected that they never have had sufficient food to eat; among whom 8.1% belongs to age group of 5-9, where as 74.7% belongs to the age group of 10-14, and the remaining 17.2% are in the age group of 15-19.

For the great majority of the respondents there are times when they are not adequately fed. The number of respondents who never get sufficient food cannot be undermined. Quite significant numbers of people are under fed and consequently the result of which will have negative impact on their physical, mental and social development. Among the orphans most affected are below the age of 14 who are in their primary school years. Regarding food provisions for the orphans, UNICEF (2005) indicated that food consumption in an AIDS-affected household could drop by as much as 40 percent, living children at higher risk of malnutrition and stunting. This well defines the situation these orphans are in. According to the

respondents, poverty, and shortage of food were some of the main reasons for their deprivation of sufficient food.

Table 20: Distribution of respondents by age, sex and whose death saddens a child much

Age:	Response	Male		Female		Total	
		No.	%	No.	%	No.	%
5 - 9	The death of a mother	10	33.3	17	51.5	27	42.9
	The death of a father	5	16.7	4	12.1	9	14.2
	Equally both	15	50	12	36.4	27	42.9
	Total	30	100.0	33	100.0	63	100.0
10 - 14	The death of a mother	77	62.6	66	57.4	143	60.1
	The death of a father	14	11.4	11	9.6	25	10.5
	Equally both	32	26	37	32.1	69	29
	Don't know	-	-	1	0.9	1	0.4
	Total	123	100.0	115	100.0	238	100.0
15 - 19	The death of a mother	28	60.9	34	66.7	62	63.9
	The death of a father	5	10.9	4	7.8	9	9.3
	Equally both	12	26.1	13	25.5	25	25.8
	None of them	1	2.1	-	-	1	1.0
	Total	46	100.0	51	100.0	97	100.0

According to the above table 232 respondents claimed that the death of a mother saddens much more than the death of a father. Among this group of respondents 11.6% falls in the ages 5-9 while 61.6% are in the ages 10-14 and the remaining 26.8 belongs to the ages 15-19. On the contrary 43 respondents affirmed that the death of a father saddens a child much more than the death of a mother. Out of this group of respondents 20.9% are in the age range of 5-9; while 58.2% are in the age group of 10-14; and the remaining respondents are in the age range of 15-19. Those who said that the death of both a mother and a father saddens a child equally are 121 out of which 22.3%, 57.0%, and 20.7% belong to the age range of 5-9, 10-14, and 15-19 in that order.

Over half of the total respondents, 58.3%, said that the death of a mother affects a child much more than the death of a father. A study in Uganda indicates that children showing depression, distress, anger or hopelessness were more likely to be living with a widowed father than with a widowed mother, suggesting that the loss of a mother is more distressing than the loss of a father (AIDS in AFRICA, 2002). This reflection may tell the importance of the presence of a mother for a child. It also seems a natural tendency, for children need their mothers around them more than anybody else.

As table 20 presents, though the figures show slight differences, female children are more affected by the death of a mother than male children when they are in the age range of 5-9 which is a time of early childhood; but more boys are affected by the death of a mother when they are in the age range of 10-14 which is a time of middle childhood (more or less period of puberty); and when they are in the age range of 15-19 (more or less a period of adolescence) again more girls are affected by the death of a mother than boys. When these respondents are expressing what other children feel about the death of parents, they are actually reflecting their own feelings about the death of parents.

Another important issue about this particular data has been children who are in the age range of 10-14, as shown in the three response items in table 20, they would rather prefer the presence of their mothers around them. They seem highly concerned about their mothers. Scholars agree on the immediate reactions of children to death of parents. They believe that the striking responses of children to the challenges that follow the loss are: fears for personal survival; separation anxiety, impaired ability to make emotional attachments; sadness, guilt, shame, depression, and despair; problems with control issues; diminished developmental energy, loss of self-

esteem, ongoing pessimism and feelings of futility are all normal in grieving children Claudia Jewett Jarratt, 1994).

Loss of parents or orphan hood due to causes other than HIV and AIDS has been realized and treated under normal circumstances. But in the case of AIDS orphans the problem may be much more aggravated. One can imagine how these devastating problems coupled with stigma and discrimination may seriously damage the overall development of a child. Being a child of parents living with HIV may psychologically affect them to a greater extent. They always think that sooner or later, separation due to death will occur. Though it is known that death occurs to every one indiscriminately, in the case of HIV and AIDS the perception becomes different. Under normal circumstances a person strives and bears in mind to live longer. When this notion is viewed from the perspectives of children it becomes more worrying and saddening. For example, "when are you going to die, mami?" "Are you going leaving me behind?" were heart-breaking questions that were repeatedly asked by a six year old child of a woman living with HIV in Awassa. A very similar case has been heard in Adama FGD, too.

Table 21: Distribution of respondents by experience of playing out door games

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	256	63.7	65.0	65.5
No	138	34.3	35.0	100.0
Total	394	98.0	100.0	
Missing System	8	2.0		
Total	402	100.0		

Out of 394 respondents who expressed their participation regarding out door games, 65.0% affirmed their participation while 35.0% stated that

they don't participate in out door games. This figure is quite big in that it consists of nearly half of the number of respondents. Among the reasons they produced for lack of participation the following are worth mentioning: Some of the parents of other children do not allow their children to play with them implicitly for fear that HIV and AIDS would be transmitted to their children. Some of the respondents said that they themselves do not want to play with others. They mostly keep themselves isolated. On the contrary, some respondents said that the other children themselves do not want to play with them for no apparent reasons. This might happen due to the reason that the other children might fear that if they play football or have physical contact with the orphans they might contract HIV and AIDS. According to Hileyesus et al., (2002) children did not want to play games like football and other physical activities with HIV positive children; because they fear that if the child bleeds they would spread the disease. This may hold true for the non-orphaned children, too, for they are suspected of having HIV and AIDS.

Table 22: Distribution of staff respondents by participation of AIDS orphans in peer group activities

Responses	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	26	35.1	37.7	37.7
No	41	55.4	59.4	97.1
I don't know	2	2.7	2.9	100.0
Total	69	93.2	100.0	
Missing	5	6.8		
Total	74	100.0		

In connection with participation of the orphans with children having parents they expressed their opinions as in table 22. A total of 74 staff members of those eight selected target organizations in the three cities and two additional other organizations having similar programs were given the

questionnaire. Sixty-nine of them expressed their impressions while five did not respond to this particular question. Quite a significant proportion (37.7%) of the respondents said that they do participate while 59.4% reported they do not participate. They gave the following reasons for their not participating: Some of the respondents said that some of the non-orphans do not want to play with the AIDS orphans. Some other respondents stated that some of the orphans isolate themselves from joining the peer groups. Still others reported that some of the parents of the non-orphans do not allow their children to play with the AIDS orphans. Thus the staff gave corroborative opinions to what the orphans already mentioned. What the staff as well as the orphans said affirmed the prevalence of stigma and discrimination in all the study areas, which may not be exception to the other parts of the country. A research revealed that other countries have also similar experiences:

“When a child was HIV positive, school staff was generally worried about possible HIV transmission from cuts or injuries following playground fights or in the event of an accident.”
(Shalina Mehta and Suninder K. Sodhi 2004).

Table 23: Distribution of respondents by age, Sex and derogatory names, words or phrases

Responses	Age	Male		Female		Total	
		No.	%	No.	%	No.	%
Yes	5 - 9	7	11.3	7	10.9	14	11.1
	10 - 14	38	61.3	37	57.8	75	59.5
	15 - 19	17	27.4	20	31.3	37	29.4
	Total	62	100.0	64	100.0	126	100.0
No	5 - 9	23	16.8	26	19.7	49	18.2
	10 - 14	85	62.0	76	57.6	161	59.9
	15 - 19	29	21.2	30	22.7	59	21.9
	Total	137	100.0	132	100.0	269	100.0

Out of 402-sample population 395 respondents gave their view about derogatory words or phrases associated with HIV and AIDS out of which 126 accepts the prevalence of such words or phrases. Those who declared that they haven't experienced such words constitute 68.1% while 31.9% declared that some kind of derogatory words or phrases associated with HIV and AIDS are attached to them.

The respondents expressed their feelings saying that some people in one way or another like to talk about the mistake their parents made in the past. Some others lament and tell others that the orphans are victims of HIV and AIDS not out of concern but simply out of sheer lust to talk about the occurrences. Among the various types of the derogatory words or phrases the following are worth mentioning: gossiping, backbiting (*hametina manshokashok*), talking about parents, branding with nicknames, a child with bad luck (*idile bis*), child created to destroy others (*geffy*), child of a woman died to AIDS, (*enatua/enatu beaidis yemotechibat/yemotechibet*), child of a mother with AIDS (*yeaidisam lij*), beware of cobra, uncultured (*sid adeg*), child of a deceased (*yemut lij*), rude (*balege*), a person with a cobra (*balekobra*), manner less (*sirat yelesh/yeleleh*); and *quanquye* - insect-like creature that people use to frighten children in Adama. Participants of the focus group discussions also share the prevalence of such derogatory words and phrases. The respondents identified their family members, classmates, playmates, peer groups, friends, and the neighbors as people who use such unpleasant words and phrases.

Some times people do discriminate unintentionally and under normal circumstances. They consider their performances and activities as normal and appropriate. By so doing they may feel that they are becoming sympathetic to the orphans. But for the recipient, it makes them feel

different from others and instill in them a feeling of hopelessness. This view is supplemented by a study such that people often do not recognize when their words, actions, or beliefs are stigmatizing or discriminatory towards PLWHA (ICRW, 2003). These derogatory words and phrases emanating from stigma and discrimination came into being as a result of HIV and AIDS, affecting quite significant numbers of orphans.

Table 24: Distribution of respondents by attitude of people in the community towards AIDS orphans

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Sympathetic	106	26.4	26.4	26.4
Unfriendly	71	17.7	17.7	44.1
Indifferent	55	13.7	13.7	57.8
Stigmatizing	54	13.4	13.5	71.3
Caring	62	15.4	15.5	86.8
Don't Know	49	12.2	12.2	99.0
Other	4	1.0	1.0	100.0
Total	401	99.8	100.0	
Missing System	1	.2		
Total	402	100.0		

According to the responds a seemingly majority of the people in the community seem positive towards AIDS orphans. However, the reality is quite different from what the figure, 26.4% and 15.5% tell, which refer to sympathy and caring respectively. 17.7% confirmed that in their respective communities people are unfriendly; 13.7% said that the people are indifferent, 13.5% stated that people in their community stigmatize AIDS orphans. 12.2% do not know the attitude of the people, which might be either because they are young or they might be living in a community with an environment conducive to them. Nevertheless, in the scenario under consideration, 44.8% of the respondents suffer from some kind of negative attitudes emitted by the community, which may consequently affect their

social, emotional and psychological development. The result of such occurrences may be manifested at various level of their developmental stage in the forms of various behavior disorders. The orphans may also develop negative attitudes towards the society.

The prevalence of stigma may be hidden among family members. Particularly adults maintain it secrete. In the FGD with PLWHA in Awassa, participants agreed that people appear to be conscious and aware of issues related to stigma and discrimination. In fact, the situation shows some kind of positive change; but not that considerable. One of the participants said that a 12-year old child fainted when she learnt that her mother was HIV positive. This might be due to the fear of death or stigma or both.

Table 25: Distribution of staff respondents by attitude of the community towards AIDS orphans

Response	Frequency	Percent	Valid Percent	Cumulative Percent
The people are sympathetic and helpful to the children	20	27.0	27.0	27.0
They lable the orphans as children who should be excluded fr	22	29.7	29.7	56.8
The people have negative attitude towards the orphans.	8	10.8	10.8	67.6
The people finger-point at the orphans	11	14.9	14.9	82.4
I don't know	5	6.8	6.8	89.2
Other	8	10.8	10.8	100.0
Total	74	100.0	100.0	

As indicated in Table 25 supportive opinion has been obtained from the staff respondents as well. Among the total respondents, 27.0% said that the community seems sympathetic and helpful towards the AIDS orphans; 29.7% stated that the community labels the orphans as group of people to

be excluded from others; 10.8% have negative attitude towards the orphans; while the remaining 14.9% finger point at the orphans. A research made more certain the validity of these responses as in this manner: "Many AIDS orphans were stigmatized for no fault of theirs; many of these children were not HIV positive but communities ostracized them. This leaves their young minds and bodies completely mutilated. Social action has to ensure that such practices are nipped in the bud. The legal and social policing will be called upon to play pro-active role in this regard" (Shalina Mehta, Suninder K. Sodhi, 2004).

Thus, when one sees the two sets of ideas obtained from both the orphans and the staff of the organizations together, they complement each other in terms of stigma and discrimination. They justify the prevalence of stigma and discrimination at a wider scale.

Table 26: Distribution of respondents by activities peer group members do not like AIDS orphans to participate in

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	116	28.8	29.3	29.3
No	280	69.7	70.7	100.0
Total	396	98.5	100.0	
Missing System	6	1.5		
Total	402	100.0		

As table 26 indicates 396 respondents expressed their feeling with regard to participation with peer groups. Out of this, 29.3% said that their peers exclude them from different peer group activities while 70.7% have an environment favorable for them to involve in various games. According to the respondents in the FGD with the AIDS orphans, the types of activities which they are deprived of include out door games, hide and seek, jumping with a rope (*yegemed zilai*), knitting, run and follow (*abarosh*).

The reasons for their deprivation of participation in peer group activities according to the respondents are: considering them physically unfit, parents of the non orphans do not allow their children to play with them; the non-orphans don not love them, because of their parents' death to HIV and AIDS.

It goes without saying that, as members of the society, children reflect what prevails in the community. The society has not fully internalized the mechanism of HIV transmission. So, there are people who think HIV can be transmitted through personal contact. This in turn has been implanted in children and they manifest in similar reactions as their parents do.

In a focus group discussion with PLWHA, members of *Tila* in Awassa, the participants pointed out how stigma affects children seriously. One of the women said that in 2004 her picture with her two children had been posted in visible corners of the streets in the city of Awassa. On the following day her children came back home weeping from school and told their mother about those children who saw the posters asked them "Are you HIV positive?" Similarly, the children asked her, "Did our father died due to AIDS?" and the like. The children couldn't bear the new situation. They kept on asking her. The mother further mentioned that their friends never stop asking my children all about the issues related to HIV and AIDS. Their peer groups gossip about them. They point their fingers at them. The mother also said that her children always asked me whether or not they have the virus. she told them that they are HIV negative. But they could never be convinced. A social worker conspicuously describes such scenario, "If a mother goes public about her HIV status on television, her child gets it the next day at school" (Theodore de Bruyn, 1998).

According to the information obtained in the FGD with the orphans, children at times do not directly segregate orphans. They simply stop playing the games when the AIDS orphans get there to join them. They may

not directly say so not play with us. Some times, they may demonstrate indifference, or they may ignore them as if they haven't seen them. They turn their back on the AIDS orphans.

Table 27. Respondents by AIDS- related stigma and discrimination differs from stigma caused by other killer diseases

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Agree much	40	54.1	55.6	55.6
Agree	22	29.7	30.6	86.1
Partially agree	5	6.8	6.9	93.1
Don't agree	4	5.4	5.6	98.6
Don't agree much	1	1.4	1.4	100.0
Total	72	97.3	100.0	
Missing System	2	2.7		
Total	74	100.0		

Out of a total of 74 staff respondents 55.6% mentioned that they very much agree while 30.6% said they agree and 6.9% said they partially agree on the differences between stigma and discrimination caused by HIV and AIDS and other killer diseases. Though there appear variations in their agreement, 86.1% of the respondents believed the existence of difference. As is known, there are many killer diseases that leave children orphaned. But the impact of the orphan hood caused by such killer diseases is not as serious as the orphan hood caused by HIV and AIDS. This is because, according to the perception of the society, HIV and AIDS is associated with stigma and discrimination while the other diseases are considered as killers only. Hence, children who lost their parents due to HIV and AIDS are vulnerable to stigma and discrimination.

Table 28: Distribution of respondents by age and types of health problems

Types of health problems	Age						Total	
	5 - 9		10 - 14		15 - 19			
	No.	%	No.	%	No.	%	No.	%
Headache	10	32.3	39	29.6	8	20.5	57	28.2
Stomachache	8	25.8	28	21.2	8	20.5	44	21.8
Eye infection	-	-	12	9.1	2	5.1	14	6.9
Common cold	5	16.1	16	12.1	-	-	21	10.4
Ear infection	-	-	4	3.0	5	12.8	9	4.5
Other	8	25.8	33	25.0	16	41.1	57	28.2
Total	31	100.0	132	100.0	39	100.0	202	100.0

According to table 27, 202 or 50.5% of the total respondents have contracted some kind of disease. Headache and stomachache appear to be much more prevalent and affect 28.2% and 21.8% respectively. Generally speaking, significantly high proportion of orphans have health problems. This might have resulted from their poor living condition and poor diet , because the fact that great majority of the respondents are from low-income families.

To be more specific, out of the total respondents, 402, those who have health problem constitute 49.2% in the age range of 5-9; whereas 55.2% having some kind of health problems are in the age range of 10-14; and those in the age range of 15-19 who suffer from some kind of health problems constitute 40.2% of the total respondents. The greater percentage with the disease appear in the middle age range, 10-14 which is primary school age and where children spent much of their time out side their homes and this may make them vulnerable to communicable diseases.

Table 29: Distribution of respondents by provider of care and support

Response	Frequency	Percent	Valid Percent	Cumulative Percent
Governmental organization	13	3.2	3.3	3.3
Non-governmental organization	322	80.1	81.1	84.4
Both organizations	21	5.2	5.3	89.7
Idir	4	1.0	1.0	90.7
Non of them	14	3.5	3.5	94.2
Others	23	5.7	5.8	100.0
Total	397	98.8	100.0	
Missing System	5	1.2		
Total	402	100.0		

As shown in table 29 the data obtained conforms that 81.1% of the care and support services provided for orphans are made available by non-governmental organizations. The number of orphans who get such care and support constitute 94.8% of the total respondents. Out of such services, 3.2% and 5.2% have been rendered by government and jointly by both government and non-governmental organizations in that order. Individuals and mass associations such as *idir* cater for some of the orphans. The care and support services include provision of food, educational materials, health services, and financial support. The orphans get the care and support by being in a family set up. There are also some orphans, 3.5%, who do not get such support in an organized manner.

Table 30: Orphans respondents by age and sex on the availability of persons or things they like

	Age	5 - 9		10 - 14		15 - 19		Total	
		No.	%	No.	%	No.	%	No.	%
Yes	Male	28	46.7	112	50.9	39	47.0	179	49.3
	Female	32	53.3	108	49.1	44	53.0	184	50.7
	Total	60	100.0	220	100.0	83	100.0	363	100.0
No	Male	1	50.0	7	77.8	5	55.6	13	65
	Female	1	50.0	2	22.2	4	44.4	7	35
	Total	2	100.0	9	100.0	9	100.0	20	100.0

This question was set with the intention of eliciting views from the orphans regarding things they like most. It may also compel them to express things they are deprived of or they lack. Such expression of opinions could at the same time create opportunities to reveal what they miss due to the loss of parents. On the other hand, if the orphans do not have any thing they like most, there must be reasons for that, for it is humanly unnatural for a person to live with out needs and likes under normal circumstances.

A total of 366 (91.0%) respondents declared that there are things they like much. On the contrary, the remaining 30 or 7.5% stated that they have nothing to like in particular. The things they like much include, education, various types of games, eating delicious food, clothing, film watching (TV), recreation, reading books, doing good to others, they like people who care for them, going to church and becoming singer and dancer.

As traditionally our society believes education as a means of success these children may do the same, for large proportion of them love education. Quite many respondents need delicious food and clothing, which has been a reality that surrounds them. The reality witnesses the existing

deprivation of provisions in almost all aspects. They live in a situation where they don't fulfill their needs in this regard. As any child strive to satisfy her/his needs these children are looking forward to fulfilling such needs. So, what they air out can be classified as the expression of their inner needs and motives. One of the factors that implanted in them the interest of film watching and reading books might be emanated from their being isolated and thereby leads to dealing with non-human objects. If they feel that people do not want to mix with them they may be compelled to revert to isolation. Significantly many respondents expressed their feeling by saying they want to be famous singers and dancers, which may be an expression of their going out of the existing precarious living condition they are in.

In a focus group discussion with *idir* leaders in Addis Ababa, they explained by citing the reply of a 13-year old girl child, who takes care of herself and her two sisters by vending roasted cereals (*kolo*) on the street. She was asked the same question like "What do you like much?". This had been done six months ago for another data collection. She replied: " I am longing for the days when my younger sisters will have enough food to eat every day and I go to school". This expression of her feeling shows that she spent much time eking for a living and she could not have sufficient time for her school and study her lessons.

Table 31: Orphans respondents by age and sex on the availability of persons or things they dislike

Response	Age	5 - 9		10 - 14		15 - 19		Total	
		No.	%	No.	%	No.	%	No.	%
Yes	Male	11	35.5	84	51.9	29	43.3	124	47.7
	Female	20	64.5	78	48.1	38	56.7	136	52.3
	Total	31	100.0	162	100.0	67	100.0	260	100.0
No	Male	17	58.6	30	46.2	16	61.5	63	52.5
	Female	12	41.4	35	53.8	10	38.5	57	47.5
	Total	29	100.0	65	100.0	26	100.0	120	100.0

Contrary to what the respondents had been asked, about things they like much, they were also asked about things they dislike much as shown in table 31 above. The intention of this question was to give respondents the opportunity to express their attitudes that negatively affect them. Ultimately, this may become of much help to see the magnitude of stigma and discrimination from their own perspectives. Out of 380 respondents 260 (47.7% male and 52.3% female) have things they dislike much; while 65 (52.5% male and 47.5% female) don't have dislikes. As they expressed, things they dislike include; insult or scolding, belittling others, backbiting, gossiping, teasing, discrimination, fist fighting, bad behavior, starving, illness, and death. It was reflected in the FGD that most of these utterances were associated with stigma and discrimination. They expressed the deep rooted feelings that resulted from deprivation and marginalization of the orphans in connection with the loss of their parents. One of the girl child participants of the FGD who was asked about her dislikes replied: *"I hate the day most when my mother's dress was down sized to fit me. I would rather see to it as it was before and go naked than wearing it, for I want to keep it with me forever."* She said this because, she was in worn out dresses that was torn into shreds. Her parents' neighbors took her mother's dress to

a tailor and down sized her mothers dress to make it fit her and gave her to wear it. But she was not happy with what they did.

In both questions above given to extract their inner feelings referring to their likes and dislikes, they produced the reality that exists in human beings. If situations are favorable for the growth and development of the AIDS orphans, their growth and development tend to the better. The following statement in Claudia Jewett Jarratt, 1994) supports the above notion with the following expression:

"Life and people become enjoyable once again and there is increased focus on the present and the future instead of the past. There are many steps, even leaps forward, in the ability to cope. There are also setbacks, but observers sense that, overall, things are moving forward in a positive way. There appears to be more ability to create a new life, one that takes the loss into an account but is not as preoccupied with it. There is also more autonomy, as well as renewed capacity to get close and to renew attachments or make new ones. Children may change some or all of their friends, gravitating to those who have stood by, comforted, and understood them and leaving behind those who were unable to support or share the healing process."

However, the situations become unfavorable for the development of orphans if the stigma and discrimination remain unchanged. What the orphans dislike may supersede their likes and eventually their physiological and psychological development maybe hampered.

The final question set in the questionnaire was; "What do you want people in the community, village, play ground, and school to do for AIDS orphans?" Among the given responses, providing love and affection,

avoiding discrimination, provision of care and support, equal treatment with other children, and providing moral support are mentioned by significantly large number of children. Almost all mentioned above in one way or another, could be associated with discrimination, rejection and deprivation. They could be considered as the reflection of the inner most feelings of the orphans. This has been well articulated in a draft document of Ethiopia with regard to HIV and AIDS. The statement goes,

"A number of behavior change communication has been undertaken in Ethiopia to create awareness of HIV/AIDS and generate behavior change among the general population. The expected level of behavior change has, however, not occurred. Stigma, social rejection and misinformation are some of the barriers to behavior change" (FDRE, 2004).

The document further states that orphan support is one of the most important components of social and economic impact mitigation. AIDS orphans constitute a sizeable proportion of the future generation that must be properly nurtured and preserved.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the discussions in light of the data obtained from the questionnaire, FGD and interview. Following the discussions, it also incorporates conclusions and recommendations.

5.1 Conclusions

It is not the interest of this research to address the problems of HIV and AIDS-related stigma and discrimination in isolation from other non-AIDS orphans and vulnerable children. If they are separately supported, they may be exposed to further stigma and discrimination. People identify and stigmatize them. This, however, does not mean that they do not need special treatment. Poverty and the loss of parents equally affect both AIDS orphans and non-AIDS orphans and vulnerable children. Nonetheless, those AIDS orphans have a special problem in connection with HIV and AIDS. They become victims of stigma and discrimination associated with HIV and AIDS that would be deep rooted before and may continue after the death of their parents.

As demonstrated in different FGD conducted for this research, there appears a consensus that most people are much aware of the mode of HIV transmission. What contradicts their knowledge has been what they practically do on the ground. For one thing they mix their knowledge with the wrong perception they have had about HIV and AIDS transmission, stigma and discrimination.

As Alemayehu Bishaw (1997) presented citing various researchers, the desired awareness of AIDS transmission with the required behavioral change had been thought to be better attainable through teaching formally in schools and teaching the community informally through various mass media, anti-AIDS clubs as well as using other mechanisms available in the

community. The studies pronounced that the intervention programs have increased the level of knowledge in the society; but, in practical terms, no considerable changes with regard to the desired behavior appeared on the ground. So, the situation necessitates the revisit of the existing programs which include policy, practical guideline and legal instruments as well as care and support interventions, information, education, counseling and awareness raising programs.

The researcher found it very difficult to identify as to who could be an AIDS orphan or non-orphan. Because the issue of HIV and AIDS has remained a secret agenda, no one, with the exception of a few individuals, dares to openly declare her/his HIV status. Most orphans do not know that their parents died of AIDS. Neither relatives nor neighbors tell them openly the cause for the death of the children's parents unless they intend to insult the orphans. Even medical personnel in health institutions do not disclose the matter without the consents of PLWHA or the orphans for fear of human rights violation.

Thus, identification of the cause of their AIDS orphan hood may be done either through hearsay, or observing the concurrent death of spouses or due to some kind of access to health institutions, or when the orphans themselves declare to get care and support from concerned organizations. Family members can tell the information as well. Such conditions may sometimes push some individuals to falsely declare that they are AIDS orphans for the sake of claiming the advantage set forth for them. As a result the available provision may, in turn, be depleted and affect the care and support programs of the true orphans.

Those who do not bear the pressure of stigma and discrimination may refrain from reporting to the relevant persons or sectors and remain away from the timely care and support programs. Eventually, they would rather

look for other means of eking out a living. Their last option could be dropping out of school. Male orphans may join streetism while female orphans join either prostitution or streetism.

Children naturally feel, hear, see and observe, all through their period of childhood, what is taking place in their surroundings. They learn and understand the HIV status of their family members from the social setting. The family of a child may be excluded from social activities initially for reasons she/he doesn't know. Eventually, the reason for that could be the parent's being HIV positive. The child may learn all about the story from her/his Peer groups in a manner that makes her/him feel shame. Peer groups may not easily erase the prejudice they have already established in connection with AIDS orphans.

In this research, it has become evident that stigmatization, discrimination, social isolation, dropping out of school, moving away from friends and family members, and bearing an increased workload in the home heighten the stress and trauma that accompanies the death of parents. We have also seen the current manifestation of discrimination as becoming more subtle, indirect and systematic, and at times direct. Some people condemn stigma and discrimination while systematically they themselves stigmatize and discriminate. For instance, as mentioned in the FGD with AIDS orphans, their peer groups stop playing games when they go near the playing places. At times some children disperse when they see the AIDS orphans going to them.

AIDS orphans are vulnerable to developing behavior disorder unless they get alternative caring and understanding families. If families who can create non-discriminatory environment take in these orphans, eventually, they may accept the reality and get on with life. Such children, having survived the worst, become ready to get back to the process of living,

growing and developing. When this happens, there will be a noticeable ground for returning to a balanced perspective and a better physiological and psychological well-being. The reality of the loss may become part of their makeup in life. The past happening may not have such profound impact on their self-esteem.

In the FGD with women living with HIV, some of them were of the opinion that children living with the virus have to be informed about their HIV status. This avoids mystification, minimizes gossiping and above all, helps the child to take precaution not to transmit the virus to others; and on the part of other people around her/him, it will help them to take measures in order to protect themselves. Others believe that telling the child about her/his status means damaging the future of the child. If the child gets information about the status, depression, distress, hopelessness and desperation could prevail that may ultimately lead her/him to unforeseen psychological damage. So, these parents strongly oppose the transmission of information to the child. But the researcher took the former position in that hiding from children things particularly that concern them may highly affect them in terms of their rights and psychological factors. Fundamentally, it is directly violating their rights. Exclusion from obtaining information suggests causing one of the forms of stigma and discrimination. Children in particular need clear and accurate information about how AIDS is transmitted so that they won't avoid the individual who is ill or overreact in other ways. In simple terms, they should be told about how the germs that cause this serious illness are transferred. But it should be noted that the term that can be used when giving information to children need to be put into the children's vernacular for easy understanding of concepts. Most importantly, children need to know that they can't get these germs by just being with people who are sick or playing with them or touching them or their things or hugging them or breathing the germs in. Children should also be told clearly that people living with HIV and AIDS or who become ill

need to get the same kindness and sympathy they used to get before the occurrence. They should be able to relate the condition that one needs and expects from others when she/he is in the same situation.

School children spend most of their daytime with schoolmates and teachers. If the school environment is not conducive for the AIDS orphans their problems become complex. Their loss of parents, separation from siblings, being placed in a new family, compounded with the stigma hurts them seriously. Because children realize situations in their own rationality and capacity to understand, it makes it difficult for them to take in things as adults commonly do. In times of a crisis with their classmates, they may not be sympathetic as such. On the contrary, at times, they may demonstrate a cruel behavior to one another; but, they can show a strong intention and desire to help others in times of crisis if some one suggests ways for them how to be supportive. It is when they are not helped to understand as to how to respond to children who are in a crisis that they show cruel behavior or become indifferent. From such stand point much remains to be done in the schools.

Notably, the absence of legal and policy instruments has not been the only cause that made stigma and discrimination against people living with HIV and AIDS in general and AIDS orphans in particular prevail. Lack of implementation and enforcement programs on the already existing laws and policies, poverty, socio-cultural barriers, inadequate commitment on the part of the government and the low level of awareness of the society are the main causes to be underscored. Directly or indirectly, the present laws and policies can serve the purpose of stigma and discrimination against AIDS orphans if genuinely people take initiatives to protect and support such children.

The prevalence of HIV and AIDS has been in every corner of Ethiopia though the numbers vary. As presented in various literatures as well as in this finding, different types of intervention programs in connection with HIV and AIDS prevention and control have been undertaken in various places among which peer education approaches such as child to child, teacher to teacher, soldier to soldier, youth to youth are worth mentioning.

As mentioned in the FGDs, the use of mass organizations like *idir* as a proper channel to provide care and support for AIDS orphans by the NGOs is something to be highly underscored. Government institutions attempt to do the same. Such diversion of attentions of almost all people who work in communities towards such organizations has become a common practice today. Focusing on them, in fact, could be a wise decision. Active participation of *idirs*, on one hand, in development activities may be considered as deviation, on the part of their members, from their intended objectives to provide support in times of death of family members. On the other hand, their capacity may not permit them to shoulder on all activities coming from all sectors of the society. Quite many practitioners fear that the *idirs*, eventually, may financially be drained and become unable to meet their objectives of establishment. In the end, they can be frustrated and misunderstanding among members may possibly arise. Then, they could collapse and the activities they currently undertake may fall apart. We may lose the only effective social institutions in almost all parts of the country. For example, in areas where the selected non-governmental organizations operate, *idirs* have been well organized and they enthusiastically mobilize the communities to take care of AIDS orphans in their own vicinities.

However, these *idirs* complained that they do not receive sufficient support from the relevant governmental organizations. Because gaps seem to exist in this situation, bridging undertakings are required. Building of

their capacities in terms of finance, human power and other resources are fundamental to a full care and support service for the AIDS orphans. Because every individual in a community joins *idir* and the leadership reside in every community, they are the closest community based organizations to reach orphans and vulnerable children. They facilitate easy access to provide not only material support but also psychosocial support as well. They could be taken as culturally appropriate agents with low cost activities to improve resilience and coping mechanisms of the affected children. They can easily have a close follow up and easy monitoring and evaluation activities in connection with the over all situations of the AIDS orphans.

This finding witnessed the prevalence of stigma and discrimination against AIDS orphans, though with varying magnitudes. For the fact that the lifestyles of the three cities appear to be more or less similar, the expression of stigma and discrimination seem to have similar characteristics. The problems significantly pervade families, schools, peer groups and communities at large. no one denies the positive change in the knowledge of the society towards the problem of stigma and discrimination. But, positive practices have not yet been considerably realized. PLWHA in general and AIDS orphans in particular suffer from the negative effect of HIV and AIDS.

The present Constitution of Ethiopia clearly articulates laws that are very much linked to basic human rights issues. The international human rights conventions are also additional instruments that can be applied to the protection of AIDS orphans against HIV and AIDS-related stigma and discrimination. In addition, The protection, care and support programs require a strong legal framework and policies that directly address the challenges facing AIDS orphans with regard to stigma and discrimination

along with care and support services. The promotion of a culture of respecting the fundamental human rights enhances the implementation of child rights.

Stigma and discrimination in the case of orphans have been discussed in this study. The existing intervention program in the country adheres to only PLWHA who comprise only the adult group of the society. It does not directly address the issue of AIDS orphans. Neither the laws nor the social policies do incorporate the problems of AIDS orphans in terms of stigma and discrimination. If at all there exists mention of AIDS orphans in the legal and policy instruments it mainly targets on care and support programs only.

The provision of care and support for people affected and infected with HIV and AIDS promotes the prevention and control of HIV and AIDS. It involves the participation of all sectors of the society without which it will be impossible to realize it. The activities require the undertaking of every member of the society both as an individual and as a group.

It goes without saying that the provision of appropriate information and education to general public regarding HIV and AIDS in an appropriate modality also contributes a lot to the prevention and control of the virus and ultimately of stigma and discrimination associated with it.

When the term AIDS is affixed to orphans, it seems to suggest a meaning of discrimination. It isolates the children from other orphans as some practitioners agree. So, in this regard, psychologists and social workers and concerned practitioners should come together, discuss and coin a better term. The term or phrase that will be suggested should not be something that can have negatively connotative meaning.

The Convention on the Rights of the Child, which has been globally almost unanimously ratified and the African Charter on the Rights and Well-being of the child which Ethiopia has also ratified are sufficient legal instruments to care, support, and protect children in general and AIDS orphans in particular from all forms of abuse, neglect, exploitation, stigma and discrimination. Full scale and intensive implementation has not been observed on the ground due to various reasons of which poverty, lack of awareness and lack of adequate commitments on the part of all sectors of the society are the major ones. This calls for the exertion of all efforts of all stakeholders and speeding up of extensive implementation programs on the rights of children within the limits of the existing economic and social conditions of the country.

Finally, the researcher concludes by citing how the Greek tradition perceives the intergenerational relationship of human race. It seems self explanatory that best explains the social bargains between the off spring, the adult and the old cohorts of the society. This, notion at this point in time- a time of high prevalence of HIV and AIDS, the intergenerational issues are very critical. The saying, being linked to a vine, goes:

" The young adults stand straight and firm as the new shoots climb up and the old ones make their way down to the earth. If you take out of the middle support, the children can't climb and the old collapse."

This is what exactly HIV and AIDS do to our society. We are just losing the cream of our generation- the middle support that could shoulder responsibilities of all dimensions as well as the whole fabrics of the social organizations. So, we shall be determined to fight against HIV and AIDS maximum efforts and commitments. The control and prevention of HIV and AIDS have to be one of our highest priorities in our endeavor to develop the country.

5.2 Recommendations

1. Primarily, stigma and discrimination do not necessarily manifest themselves openly. They may not be conspicuously manifested in most cases. Thus, the fight against it demands conscious and systematic follow up undertakings in every community where the prevalence of AIDS orphans becomes obvious. Such activities necessitate the establishment of networking of stakeholders. This network cannot be a kind of mechanism that simply does the conventional types of work. Since the issue of stigma has hidden nature, members of the net works should work closely with both members and the orphans. A system for recording of happenings with regard to the issues of stigma and discrimination against AIDS orphans should be in place for further discussions, course of actions and follow up.
2. Because of the immensity and complexity of the problems of stigma and discrimination against AIDS orphans, the challenges are so huge that efforts of a few concerned organizations can not do much to improve the situations. The participation of the entire society contributes a lot towards ameliorating the problems. The community needs to be mobilized in terms of expertise and finance to this effect. Systematically organized mechanisms such as 'youth fund' have to be in place for voluntary financial contributions. It could be a sort of organization where every citizen in the country can contribute periodically. At the same time, establishing a club in each locality where people with different knowledge and experiences come together and share their contributions with others draws knowledge from resource persons that could be of much help in the endeavor to avoid the problems.
3. Activities designed to eliminate the prevailing problems of HIV and AIDS- related stigma and discrimination against AIDS orphans necessitate strategic plan that are designed through the participation of all stakeholders including the orphans themselves. The plan should

incorporate intervention programs that can address psychosocial, material, financial and additional legal and policy issues in connection with AIDS orphans.

4. The on going programs designed to prevent and control HIV and AIDS through the promotion of education and dissemination of information using media, needs to be revisited so as to avoid the kind of information that promote fear and, eventually, which would increase stigma and discrimination. An organization has to be careful in designing the type of information it is going to disseminate in order to raise awareness of the society at large. The information and education regarding stigma and discrimination should be culture bound and simplified to be understandable without producing unintended meaning apart from its intended objectives. The mechanisms through which the information is transmitted to children need to be in compliance with the level of education and appropriate to the age of the children. Such practices require the involvement of professionals in the field social development, for conscious and systematic measures enhance and strengthen attitudinal changes in this regard.
5. Parents and teachers should be well informed about matters associated with HIV and AIDS including the inevitability of death in any case so as to enable them to educate their children about facts regarding death and grief in age or developmentally appropriate ways. Thus, when parents die, the orphans can have the capacity to explore and understand more about the reality of death and normal grief reactions. They can face death accordingly. mass media in this regard have much role to play if they are systematically and consciously utilized.
6. School communities that include students, teachers, head masters, responsible persons at all levels, and all members of the administrative staff, all relevant government organizations and non-governmental organizations should bring hands together and enthusiastically do whatever is expected from them. Every sector needs to communicate

with each other to be well informed about the development of the orphans in all aspects in their localities.

7. Networking among care and support providers, families, schools , health institutions, psychosocial support service providers and the local or *kebele* authorities becomes crucial for the sustainable care and support of AIDS orphans.
8. Implementation of programs designed to address the problems of stigma and discrimination against AIDS orphans can effectively be successful when the society undertakes them through its community-based organizations such as *idir*, *mahiber*, and other similar associations. Policy makers such as MOH, MOE, HAPCO and other stakeholders in partnership with relevant UN, bilateral and multilateral organizations as well as NGOs have significant roles to play in facilitating activities and strengthening capacities of community based organizations.
9. Along with food, shelter, clothing, education and health services, AIDS orphans should also be provided with appropriate guidance and counseling (Psychosocial services) which are the fundamental components of their rights.
10. The implementation of programs designed for people affected with HIV and AIDS have to involve youth, for they have capacities to take initiatives, create new ideas and approaches and to actively undertake activities. Organizing them requires their prior consent and willingness. Male youth and female youth have to be organized separately for the purpose of dealing with their respective sexes in order to avoid inhibition on the part of PLWHA towards opposite sexes and their by create an environment of openness. It usually seems a natural tendency for a person to feel free, relaxed, and comfortable when expressing her/his feelings and problems to a person of the same sex.

11. Further research with regard to the situations AIDS orphans and the impact of intervention programs need to be conducted for a better future course of action.

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Appendix 1

Questionnaire for Orphans

Code:-----

The purpose of this questionnaire is to gather information pertaining to orphans in selected cities of Ethiopia (Addis Ababa, Nazaret, and Awassa). Your response to each question is crucial and, above all, significant contribution for the study. Any data obtained through the use of this questionnaire will not be used for any other purpose except the intended research. Thus, I would like to extend my prior thanks for your cooperation.

I. Personal information

1. Address: Region_____ City_____
- Sub city_____ Kebele_____ House No._____
2. Age: _____
3. Sex: Male _____ Female _____
4. Nationality: 1. Gurage 2. Amhara 3. Wolita 4. Oromo
5. Sidama 6. Tigray 7. Other (specify)_____
5. Religion: 1. Orthodox Christian 2. Muslim 3. Protestant
4. Catholic 5. Other (specify)_____
6. Parents lost: 1. Father only ____ 2. Mother only ____ 3. Both ____

II. Education

7. Your current school enrollment:
1. In government school 2. In private school
3. In religious school 4. Dropout 5. Never been enrolled
6. Expelled from school 7. Other(specify)_____
8. Your current educational grade level _____

9. If you are a dropout or you have never been enrolled in schools, what is the reason for that?

1. Poor economic situation of family
2. Unwillingness of family to send me to school
3. Death of my parents
4. My ill-health
5. Ill-health of my parents
6. Lack of interest on my part in education
7. Other (specify)_____

10. How is your participation in classroom activities?

1. Always participate
2. Rarely participate
3. Never participate
4. The teacher does not give me a chance
5. Other (specify)_____

11. How is your participation in sports activities?

1. Always participate
2. Rarely participate
3. Never participate
4. Nobody gives me a chance
5. Other (specify)_____

12. How is your participation in school clubs?

1. Fully participate
2. Rarely participate
3. Never participate
4. No clubs
5. Other (specify)_____

13. Is there any teacher that you don't like?

1. Yes
2. No

14. If yes, what is the reason that you don't like her/him?_____

15. Are there classmates that you don't like?

1. Yes

2. No

16. If yes, what is that you don't like about your classmates? _____

II. Family situation:

17. How old were you when your parent/parents died? _____

18. What causes are attributed to the death of your parents?

1. Tuberculosis

2. Accident

3. drought

4. Unknown

5. Other (specify) _____

19. What did your late parents do to express their love to you?

1. They always used to cuddle me

2. They used to let me to freely act and play at home

3. They used to provide me as much as they could whatever things
I needed

4. Don't remember

5. Other (specify) _____

20. Do you have siblings?

1. Yes

2. No

21. If yes, do you currently live together ?

1. Yes

2. No

22. Who is currently taking care of you? (**Data collector:** There may be more than one answer)

1. My relatives
2. My parent's friends
3. our neighbors
4. My siblings
5. Myself
6. An organization
7. Other (specify)_____

23. If you are living in a family having their own biological children how do they demonstrate their love to all of you?

1. They cuddle me as they do to their children
2. They pay me less attention than they do to their children
3. They are indifferent to me
4. Other (specify)_____

24. How do the other family members treat you?

1. Friendly
2. Unfriendly
3. Indifferently
4. Half-heartedly

25. How is the dining practice of your current family?

1. Each member dines individually
2. The entire family dine together
3. Every child dines individually while parents dine together in the same plate
4. Children dine in a separate group while adults dine in another group
5. Other (specify)_____

26. Are there separate utensils only you use for eating or drinking ?

1. Yes
2. No

27. If "yes", why do you think it is? _____

28. How much is the monthly income of your current family? _____

29. Do you get sufficient food to eat?

- | | |
|-----------------|--------------------------|
| 1. I always get | 2. I get sometimes |
| 3. I never get | 4. Other (specify) _____ |

30. If your response is "never get" why?

1. Because of food scarcity
2. Because I don't have the appetite to eat much
3. I don't know the reason
4. 4. Other (specify) _____

31. Is the death of a mother or a father, you think, that saddens a child much?

- | | | |
|--------------------------|--------------------------|---------------|
| 1. The death of a mother | 2. The death of a father | |
| 3. Equally both | 4. None of them | 5. Don't know |

32. Areas in which you get less opportunities than the rest of the children in your current family? (**Data collector:** More than one answer could be given).

- | | | |
|---------------------------|-----------|------------|
| 1. Education | 2. Health | 3. Feeding |
| 4. Expression of opinion | 5. Play | 6. Nothing |
| 7. Others (specify) _____ | | |

33. Do you play games, such as football, with the other children in the family?

- | | |
|--------|-------|
| 1. Yes | 2. No |
|--------|-------|

34. If no, why?

1. The family does not allow them to play with me
2. I don't want to play with them
3. They don't want to play with me
4. All of us do not want to play together
5. Other (specify)_____

III. Community situation

35. Are there derogatory names, words or phrases attached to you by others?

1. Yes
2. No

36. If "Yes", write down the names, words or phrases. _____

37. If your response for question 33 is yes, from whom do you hear such words or phrases first? (**Data collector:** There may be more than one answer?)

1. From the family members
2. From play mates
3. From classmates
4. From the neighborhood
6. Other(specify)_____

38. How do you perceive the attitude of the people in your community towards HIV/AIDS orphans?

1. Sympathetic
2. Unfriendly
3. Indifferent
4. Stigmatizing
5. Caring
6. Don't Know
7. Other (specify)_____

IV. Peer attitude

39. In which of the following places do you have friends?
1. In the neighborhood 2. In the school
 3. Both in the neighborhood and in the school
 4. Have no friends at all 5. Other places (specify_____)
40. Are there activities the peer group members do not like you to participate in?
1. Yes 2. No
41. If "Yes" what are the activities?_____
42. If your response for question 38 is "yes", what do you think are the reasons?_____

V. Health status

43. Do you have any health problems?
1. Yes 2. No
44. If yes, what are they? (**Data collector:** There may be more than one answer)
1. Headache 2. Stomachache 3. Eye infection
 4. Common cold 5. Ear infection 6. Other(specify)_____
45. What would be done for you all, the children, whenever you have ill-health?
1. We would be taken to health center
 2. We would be taken to a traditional healer
 3. We would be taken to holy-water (*tebel*)

4. We would be given local medicine
5. Other(specify)_____

VI. Service provision

46. From which of the following organizations do you get care and support? (**Data collector:** More than one answer could be given)

1. From governmental organization
2. From non-governmental organization
3. From both organizations 4. Non of them 5. "Idir"
6. Other(specify)_____

47. What are the services that you are provided with? (**Data collector:** more than one answer could be given)

1. Provision of food 2. clothings 3. Educational materials
4. Financial support 5. Provision of health services
6. Counseling services 7. Other(specify)_____

VII. General attitude:

58. Are there things you are very much fond of?

1. Yes 2. No

59. If "Yes" what are they?_____

50. Are there things you very much dislike?

1. Yes 2. No

51. If "Yes" what are they?_____

52. What do you want people in your community, in the village, play ground, and school, to do for orphaned children? _____

◆ Name of data collector:-----

◆ Signature of data collector:-----

◆ Date of data collection-----

Appendix 2

Questionnaire for people working with HIV/AIDS Orphans

This questionnaire is designed to gather information pertaining to stigma and discrimination against HIV/AIDS orphans. It is to be answered by staff members working with the orphans in selected non-governmental organizations in Addis Ababa, Awassa and Nazareth. Your response to each question is crucial and, above all, significant contribution for the study. Any data obtained through the use of this questionnaire will not be used for any other purpose except the intended research. Thus, the researcher would like to extend his prior thanks for your cooperation.

Note: 1. A number of answers may be given for some of the questions. Thus, you may do so as required.

2. If you need more space for additional answers you may use the plain back page

1. Name of your organization: _____

2. Address : Regional state _____

City: _____ Sub-city: _____

Kebele: _____

3. Your Occupation: _____

4. Do you see clear difference between the meaning of stigma and discrimination?

1. Yes

2. No

5. What are the causes of stigma and discrimination Against HIV/AIDS? (More than one answer may be given)

1. Lack of detailed knowledge of the society about the transmission of HIV/AIDS

2. Incorrect knowledge of the society about how HIV is transmitted

3. Fear of contracting HIV through casual contact with the orphans

4. Labeling the children as children of parents having "deviant behavior" regarding sexual practices

orphans?

6. Are there derogatory words or phrases that are attached to HIV and AIDS orphans?

1. Yes

2. No

7. If yes, what are they? _____

8. How is the relationship between the orphans and their new families at home?

1. Mostly families have very good relationship

2. Families have mild relationship

3. Mostly families have no good relationship

4. I don't know

5. Other (specify) _____

9. How do the new families or guardians treat the orphans?

1. Most families discriminate them

2. Some families discriminate them

3. Some families treat them equally as they treat their own children

4. Most families treat them less than they treat their own children

5. Don't know

6. Other (specify) _____

10. Do you know orphans who are excluded or expelled from schools in connection with HIV/AIDS ?

1. Yes

2. No

11. If yes, how many are they _____

12. Do the orphans actively participate in school activities?

1. Yes

2. No

13. If no, why do you think it is? _____

14. What is the attitude of the people in the community towards the HIV/AIDS orphans?

1. Most people fear as though AIDS orphans transmit the virus

2. Some people fear as though AIDS orphans transmit the virus

3. Most people do not allow their children to play with AIDS orphans

4. Some people do not allow their children to play with AIDS orphans

5. Don't know

6. Other (specify) _____

15. Do these orphans freely participate in peer group activities?

1. Yes

2. No

16. If no, why?

1. The non orphans do not want to play with the AIDS orphans

2. The AIDS orphans isolate themselves

3. Parents do not allow their children to play with the AIDS orphans for fear that their children will contract the virus

4. Don't know

5. Other (specify) _____

17. Do you think HIV/AIDS-related stigma and discrimination is different from stigma and discrimination caused by other factors?

1. Strongly agree 2. Agree 3. Partly agree 4. Disagree 5. strongly disagree

18. What types of behavior do HIV and AIDS orphans manifest as a result of stigma and discrimination?

1. Withdrawal from peer group activities

2. Mostly quarrelsome

3. Stressful

4. Don't know

5. Other (specify) _____

19. What are the problems that these orphans face as a result of HIV/AIDS-related stigma and discrimination?

1. Lack love and care of their guardians

2. Isolation by peer groups in their locality

3. Isolation by fellow-mates in the school

4. Lack of schooling or dropping out of school

5. Others finger point at them

6. Health problem

7. Other (specify) _____

20. What intervention programs are underway in your organization to combat HIV/AIDS-related stigma and discrimination? _____

21. Do you think that these intervention programs have brought about significant positive changes?

1. Yes

2. No

22. If yes, what are the positive changes? _____

23. If no, why? _____

24. What do you recommend for a better future action? _____

Appendix 3

Questions for focus group discussion With people working for HIV/AIDS orphans

These issues are raised for the purpose of collectively gathering information through discussion. The information will be used only for the research. The researcher would like to assure that individual participants of the focus group discussion may not be quoted in the research for what he/she mentioned without his/her consent. If cases of orphans are to be included in the research, it is of no doubt, code name will be used.

I. Organization:

1. Name of organization _____
2. Years of service for HIV/AIDS orphans _____
3. Number of HIV/AIDS orphans who receive service _____
4. Number of staff providing services: Professionals----- Semi-professionals-----
Non-professionals-----

II. Causes and manifestation:

5. What are the causes for HIV/AIDS-related stigma and discrimination?
6. In what ways are such stigma and discrimination manifested at home, in schools, among peer groups and in the community?
7. What are the factors, if there are, that make HIV/AIDS-related stigma and discrimination so different from stigma and discrimination caused by factors other than HIV/AIDS?
8. What are the problems these children are faced with as a result of HIV/AIDS-related stigma and discrimination?
9. Are there derogatory words or phrases associated with HIV/AIDS and attached to the orphans? If yes, what are they?

III. Intervention programs:

10. How high a priority is the mitigation of stigma and discrimination against HIV/AIDS orphans?
11. Are there focused programs of intervention so as to eliminate stigma and discrimination against HIV/AIDS orphans? If yes, what are they?
12. Do you believe that the existing intervention programs have brought about significant changes? If not why? If yes, what are the changes that are observed?
13. Do you know cases of orphans who faced very serious problems in connection with HIV/AIDS-related stigma and discrimination? If yes, would you briefly explain the situation?
14. What do you recommend as future course of action to eliminate HIV/AIDS-related stigma and discrimination other than what has already been mentioned?

Appendix 4

Questions for focus group discussion with HIV/AIDS orphans

These questions are prepared for the purpose of gathering information through group discussion. The information will be used only for the research purpose on HIV/AIDS-related stigma and discrimination. The researcher would like to assure that the discussants may not be quoted, without their consent, in the research for what they mentioned. If cases of orphans obtained through the discussion are to be included in the research, it is of no doubt, code name will be used.

1. Name of the organization where they come from-----
2. Could we start our discussion by introducing each other i.e. telling name, age, whether we are half orphan or full orphan and whether we are currently in school or not?
3. What do you know about HIV/AIDS- related stigma and discrimination?
4. What are the causes of stigma and discrimination against HIV/AIDS orphans?
5. How are such orphans perceived by their care-takers or guardians or family members, by the school community, By peer group, and by the community?
6. How do the orphans, on the contrary, see their care-takers, or guardians or family members, the school community, peer groups, and the community at large?
7. What are the problems the orphans are faced with as a result of HIV/AIDS- related stigma and discrimination?
8. Are the existing or current stigma and discrimination the same as they were two or three years ago?
9. What are the factors that perpetuate the problems of HIV/AIDS-related stigma and discrimination against HIV/AIDS orphans?
9. What are the measures taken to mitigate such stigma and discrimination?
10. Do you know worth citing cases of orphans who faced serious problems in connection with HIV/AIDS-related stigma and discrimination? If yes, would you briefly explain the situation?
11. What are your recommendations for future course of action to effectively mitigate the stigma and discrimination against HIV/AIDS?

Appendix 5

Interview Questions for Key Informants

These questions are prepared for the purpose of gathering information through discussion. The information will be used only for the research purpose on HIV/AIDS-related stigma and discrimination. The researcher would like to assure that interviewees may not be quoted, without their consent, in the research for what they mentioned. If cases of orphans obtained through the interview are to be included in the research, it is of no doubt, code name will be used.

1. Name of organization: _____
2. Address : Regional State-----City-----Sub-city-----
-----wereda-----Kebele-----
3. Occupation of interviewee:-----
4. How is HIV/AIDS stigma differentiated from discrimination?-----
5. What is your opinion regarding the perceived attitude of the general public towards HIV/AIDS orphans in the context of stigma and discrimination?-----
6. Do you think that HIV/AIDS stigma and discrimination is different from other forms of stigma and discrimination caused by other factors? **Yes** **No**
If yes, in what ways?-----
7. What do you think are the causes for the occurrence of HIV/AIDS-related stigma and discrimination against orphans?-----
8. What factors or conditions, in your opinion, perpetuate HIV/AIDS stigma and discrimination?-----
9. In what forms are these stigma and discrimination manifested?-----
10. What are the observable implications of such stigma and discrimination against HIV/AIDS orphans?-----
11. What are the common problems these orphans are faced with as a result of HIV/AIDS-related stigma and discrimination
12. Are there derogatory words or phrases associated with HIV/AIDS orphans?

1. Yes

2. No

13. If yes, what are they?-----

14. Do you believe that HIV/AIDS-related stigma and discrimination that had been attached to parents are subsequently transmitted to their children?

1. Yes

2. No

15. If yes, why?-----

16. Which segments of the society are the perpetrators of the problems?-----

17. What coping mechanisms do such children, in your observation, employ to positively tackle such difficult situations?-----

18. How much of a priority, in your opinion, should be the mitigation of stigma and discrimination against HIV/AIDS orphans?

1. High priority

2. medium priority

3. Less priority

19. If less priority, why?-----

20. Are there intervention programs that are particularly designed to address HIV/AIDS-related stigma and discrimination against these orphans?

1. Yes

2. No

21. If yes? What are they?-----

22. Do you believe that the intervention programs regarding these problems have brought about significant changes?

1. Yes

2. No

• If No, why?-----

• If yes, what are the changes?-----

23. Do you know cases of orphans who faced serious problems in connection with HIV/AIDS-related stigma and discrimination? If yes, would you briefly explain the situation?

24. What do you recommend as future course of action to arrest perpetuating factors and mitigate stigma and discrimination against HIV/AIDS orphans?-----

1. Name of the interviewer:-----

2. Signature of the interviewer-----

Appendix 6

A table showing expression and forms of stigma

<u>Physical</u>	<u>Social</u>	<u>Language/Verbal</u>	<u>Institutional</u>
Isolation • Separating sleeping quarters • Marking and separating eating utensils • No longer allowing person to eat meals with family • Separating clothing and bed linens • Confinement to certain rooms of house • No longer allowing person to participate in housework (e.g. Cooking food) • Public rejection (refuse to sit next to person on bus, bench, at church, tea shops or in bars) • Separation from children • Abandonment from family Violence	Isolation • Reduction of daily interaction with family and community • Exclusion from and shunning at family and community events • Loss of social networks • Decreased visits from neighbors Voyeurism • Increased visits from neighbors, not out of concern but to mock individual or report back to community Loss of identity/role • Viewed and treated by community as having no future • No longer considered productive member of society • Automatically associated with "social	Gossip • Speculation on how person acquired virus • Spreading rumors • Whispering behind back Taunting • Insults • Mocking • Finger-pointing • Threats Expressions of blame shame • Scolding (e.g. Blamed for not listening to elders) • Blamed for bringing "bad luck" to whole family Labeling and use of derogatory words to describe people living with HIV or AIDS	Loss of livelihood/ future • Loss of employment • Loss of customers/business • Denial of loans, scholarships, visas Loss of housing • Denied housing • Eviction by land lords Differential treatment in schools • Teachers supporting the idea of separating children of HIV+ve people to "protect" other students Differential treatment in

• Beating • Being kicked • Throwing stones • Arrests	evils" (e.g. Drug use, sex work? • Expected to adopt new role of teaching others about HIV and disclosing status • Loss of power, respect, and standing in community • Loss of right to make decisions about own life • Loss of marriage and child bearing opportunities	• In Africa: "moving skeleton", "walking corpse", "key to mortuary" • In Vietnam: "they are social evils," "scum of society" "deserve to die"	health care settings • Excessive and unnecessary precautions by health care staff • Shuffled between providers to avoid caring for HIV+ve patient • Denial of health service • Provision of substandard treatment • Use of separate medical tools for people with HIV or AIDS • Place patients with HIV in separate rooms Differential treatment in public spaces • Refusal of services (e.g. will not be served food by vendors, or not served in shared containers} Media and public health messages
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			and campaigns • Posters and news stories emphasizing negative images of people with HIV and AIDS employing fear tactics to warn about HIV and AIDS • Posters and news stories presenting factual information about HIV and AIDS with a moral and judgmental tone • Inflammatory news stories about HIV+ve individuals purposefully infecting others
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Source: ICRW (2005). Common at Its Core; HIV-Related Stigma. Across contexts.

			and campaigns • Posters and news stories emphasizing negative images of people with HIV and AIDS employing fear tactics to warn about HIV and AIDS • Posters and news stories presenting factual information about HIV and AIDS with a moral and judgmental tone • Inflammatory news stories about HIV+ve individuals purposefully infecting others
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Source: ICRW (2005). Common at Its Core; HIV-Related Stigma. Across contexts.